Witness Name: Matt Hancock
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UK COVID-19 INQUIRY

SIXTH WITNESS STATEMENT OF MATT HANCOCK

I, Matt Hancock, will say as follows:

1. I make this sixth substantive statement in response to a request from the Inquiry dated 15 February 2024 made under Rule 9 of the Inquiry Rules 2006 ("the Request") asking for a witness statement in connection with Module 4 of the Inquiry. As this Inquiry works in modules, accepting the suggestion of the Inquiry in its Request I have copied and repeated paragraphs of my Module 2 witness statement[1] where relevant to the matters under consideration in Module 4. Nevertheless this statement has been drafted as a 'stand alone' statement for the purpose of Module 4.

2. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. The Department of Health and Social Care ("the Department") continues to work on its involvement in the Inquiry, and should any additional material be discovered I will of course ensure that this material is provided to the Inquiry and I would be happy to make a supplementary statement if required. I understand that other witness statements provided to the Inquiry by the Department address the issues of key figures and decision makers in detail, although I have sought to do the same below where I was directly involved.

[1] INQ000232194

3. This statement sets out my involvement, function and responsibilities in the development and deployment of vaccines in the period between January 2020 and 26 June 2021.

4. In making this statement I would like to start with a tribute to my Departmental colleagues, civil servants, Ministers, industry experts, those within the National Health Service ("the NHS"), the scientists, regulators, rest of government, devolved administrations, councils, logisticians, the armed forces, the GP surgeries, pharmacists, the volunteer workforce and all others involved in delivering the vaccine programme. The vaccine programme was a huge team effort. I was told at the start that it would normally take five to ten years and could not be done in under a year. Not only was that achieved, but in the Oxford/AstraZeneca vaccine the UK provided doses for people around the world. In the first 12 months from approval, over 2 billion doses were given globally, with almost two thirds provided to low and lower-middle income countries, saving an estimated 6.3 million lives (MH6/1 - INQ000480971; MH6/2 - INQ000475516).

5. As the Secretary of State for Health and Social Care ("the Health Secretary" or "Secretary of State") my motivation was to deliver a safe and effective vaccine as soon as possible. From the moment I learned about the danger this virus presented I ordered immediate work on developing a vaccine. My role was to drive the programme: this meant supporting the scientific research, overseeing commercial decisions, safeguarding manufacturing, securing funding for vaccines, aligning regulators, managing the centre of Government, delivering roll-out, liaising with the rest of Government and communication with the public. Despite huge obstacles, the team rose to every challenge.

6. From the starting point of our decision to develop a vaccine in January 2020, to the delivery of the first vaccine of the Pfizer Covid-19 jab by May Parsons into the arm of Margaret Keenan at 06:31 on 8 December 2020, at the Coventry General

Hospital, had taken under 11 months. Ms Keenan's Covid-19 vaccine was the first clinically approved in the world, the start of the biggest vaccine campaign in NHS history, and the beginning of the end of the pandemic.

7. The roll out of the vaccines was no less a triumph as it was a mammoth task. General Sir Nick Carter described it as the largest civilian exercise in peacetime history. Arguably it was also the most successful. For most people, it was their best, most efficient, experience of the NHS. The vast majority of the UK population queued briefly and patiently for their jabs and people, with many volunteers, worked round the clock to make it happen. I am incredibly proud of all of the work done by everyone in the Department and beyond who worked selflessly to combat this dreadful disease.

8. I thought of the vast vaccine programme as essentially divided into four parts:

    a. Scientific research – primarily done in universities and pharmaceutical companies;
    b. Regulation – led by the Medicine and Healthcare products Regulatory Authority ("the MHRA"); and
    c. Commercial buying and manufacture – led by the Vaccine Taskforce;
    d. Deployment – led by the NHS.

9. All four of these parts were absolutely critical, and while each had different lines of accountability, they were drawn together in practice by the highly effective work of the Deputy Chief Medical Officer ("DCMO") Professor Sir Jonathan Van-Tam, reporting to me as Secretary of State.

10. The vaccine rollout was an example of a superbly delivered programme, from which many lessons can be drawn:

    a. Clear mission, with strategic and tactical goals, widely agreed and bought into;

b. Clear lines of accountability with protection from political interference;
c. High quality leadership personnel, with clear routes to resolving disputes;
d. Open permissive can-do culture, within an agreed framework;
e. Aggressive use of best available data and digital infrastructure;
f. Excellent communication across the programme by all, and
g. Adequate resourcing, with funding decisions taken off the critical path.

11. Providing leadership to a project the scale of the vaccine programme was challenging. Inevitably I was closer to some areas than others. Oxford University ran the academic research on their vaccine, funded it before the Government systems got up to speed, and formally signed the contract with AstraZeneca. There my role was encouragement, unblocking barriers in the system, and approving the big decisions – like my decision to block the proposal to license the vaccine to the US pharmaceutical company Merck.

12. In terms of the commercial arrangements around buying vaccines, BEIS formally led, but I was involved in the appointment of the Chair of the Vaccine Taskforce, providing clarity about needing to back all winners, and buy vaccine for the entire UK population, and formally taking decisions as part of a three-person Ministerial board.

13. My role with respect to regulation was rightly constrained by the fact the regulator rightly was, and needed to be seen to be, independent. My job was to ensure they had the right resources, and to encourage and support.

14. In terms of the roll-out, my responsibility was more hands-on. I chaired the daily Vaccine Delivery Board, and was involved at an operational level in the rollout plans, including logistics, communications, and policy.

15. Across these differing structures, I tried to lead using some basic rules of thumb:

a. Delegate authority on a principle of subsidiarity, and take accountability;

b. Empower the team at all levels to make decisions without fear of reprisal if it goes wrong;
c. Demand as much information as possible to make a decision, but no more than is possible;
d. Work as a team, and protect the team from undue interference and distractions;
e. When something goes wrong, ask not the question 'who is to blame?' but rather 'how can we fix this?'; and, perhaps most importantly
f. Concentrate on saving lives, not how it will look afterwards.

16. It needs to be understood that governance at the Department during the pandemic was far from business as normal. Decisions could not wait, because not to decide would itself often have consequences, sometimes much worse than any of the available decisions. This was as close to being in a war as I would ever want to get. My work as the Secretary of State changed entirely. All decisions and actions need to be seen within this context. In normal times decisions are typically made in slower time, and typically asking for more data, analysis or briefing is a perfectly reasonable choice. In the pandemic, this was often not possible. In addition, the Department suddenly had many many more executive functions. My job became much less like a Chairman and much more akin to that of a hands on managing director. There was no alternative, and rather than seeing to cover my back I took the action and took responsibility for the action that was necessary to save lives. That was my duty.

17. The work of everyone at the Department changed, people had to make decisions they would never normally have had to make at such pace. The entire Department stepped up, I could not be prouder of the work that we all did in the Departments.

18. From the very start of the pandemic, before the 30 January date set as the starting point of this Module of the Inquiry, it was clear to me that we may need a vaccine for what became known as Covid-19. This was confirmed when we discovered,

after the peak of the first wave, that only a small proportion of the population had antibodies. This fact rendered any strategy other than widespread vaccination impossible. The only way through was to suppress the virus until a vaccine made us safe. This is a vital lesson that must be understood for next time.

The Approach to Scientific Advice

19. From January 2020 onwards, the Permanent Secretary, Chief Medical Officer ("CMO") and I discussed the proper approach to scientific advice. As with all areas of pandemic response, including vaccines, my approach was not to *follow* the science but to be *guided by* the science, as presented to me by the CMO, the DCMOs and the Government's Chief Scientific Adviser ("CSA"). To "follow" the science implies accepting scientific advice without wider consideration. To be guided by the science is to take the scientific advice, and base decisions on it, taking into account reasonable challenge, operational and other wider considerations. My job as Secretary of State was to take all considerations into account in making decisions. In very large part, I would follow scientific advice - for example I followed the scientific advice from the JCVI on the prioritisation of vaccines.

20. The Inquiry has asked me about the approach taken by the Department to the advice provided by JCVI. Whilst there may have been discussion between the CMO/DCMO/others in the Department and JCVI as to the latter's advice on eligibility and prioritisation, this was an area where I followed the scientific advice provided. I commissioned that advice formally, and interrogated responses. In sensitive areas, for example on the use of the AstraZeneca vaccine for young people, I intentionally dealt with JCVI through Professor Van-Tam, rather than directly, to help preserve their independence, and I followed the scientific advice if/when matters were put forward to me for decision. My recollection of Professor Wei Shen Lim of JCVI is with the deepest respect for his integrity, experise and professionalism.

21. A good example of the interaction of scientific advice and Ministerial decision making was the decision to extend the vaccine dose interval in December 2020, meaning that we could vaccinate more people more quickly. My political advisor spotted a Tweet from a US statistician suggesting the logic behind this proposal, because the life-saving power of the first vaccine dose is higher than the second. I understood the idea, and considered that it could be beneficial, and the barriers – for example with respect to approvals processes – could be overcome. I took the idea to the DCMO and CMO, who, after due consideration, agreed that it would likely save lives. They asked if I thought the public would accept the change, and I judged they would, so long as it was clinically approved. The DCMO then worked rapidly with MHRA and JCVI to get their agreement, and I worked with the NHS vaccine programme team on the logistics, including scheduling of appointments, communications, and handling those who already had had one dose. We took the plan to the Prime Minister who signed it off, and within 9 days we had gone from an idea to a full-blown policy. This isn't "following" the science in a formal sense, but very much being guided by the science. The Department announced the change in policy, and analysis afterwards showed that over 10,000 lives had been saved (MH6/3 - INQ000399450; MH6/4 - INQ000234331).

22. I give this as just one example to show the how the interaction of scientific advice and national leadership worked in practice. This is just one instance where consideration was given to wider operational matters and I provided reasonable challenge in respect of the approach to vaccines.

Backing the Vaccine

23. From the first meeting in which we discussed this new disease on 6 January 2020, and especially from the moment on 28 January that I set the mission to achieve a vaccine within a year (MH6/5 – INQ000233747) , we focussed on a vaccine as the route out of the pandemic.

24. Delivering the vaccine took a massive effort from a very wide range of partners. The vaccine programme comprised four elements broad: academic research; commercial development and purchase; smart regulation; and operational delivery, all underpinned by excellent data.

25. We worked hard to gather data through each stage of the vaccination programme: research; purchasing; regulation and rollout, and to use modern data techniques. For example, the great success of the vaccine rollout shows that the NHS can and should interact with patients using modern digital techniques; here the data (i.e., contact data) was available through normal sources, but it was the deployment of it through modern means that was excellent.

26. General sources of data included:
    a. data from clinical studies and trials;
    b. NHS activity data;
    c. epidemiological data;
    d. genomic data;
    e. data from virological studies;
    f. qualitative and quantative social science data; and
    g. data from the private sector.

27. Palantir supported the vital, lifesaving, work to collate and manage the data inputted from different sources, but principally the vaccine rollout was based on the summary care record available on the NHS Spine. When a vaccine was delivered, this was added to the summary care record, so that there was a caonical record of vaccination events. This allowed for a highly efficient logisitical system to be build by local vaccination centres, whether run by GPs, pharmacists, NHS bodies or others.

28. To my mind, the use of data during the Covid-19 pandemic demonstrates the ability of the NHS to operate a quasi-Stage 4 trial in respect of pharmacovigiliance, but in order for it to do this effectively, it must have the right data architecture in place.

29. Right from the start, we made some crucial decisions that underpinned the success of the vaccine programme:

    a. First, the decision to back *any* safe and effective vaccine;
    b. Second, the decision to throw all possible resources at making it happen as soon as possible; and
    c. Third, the decision to provide vaccines for the entire population, and demand exclusive access to early doses.

30. It is true that, even at the time, many people did not think that development of a vaccine would be possible in the timescale I had set out. Many people (including anonymous briefings across Whitehall, for example, which suggested that my drive for a vaccine was a "joke") and criticised me for pushing so hard for vaccines for all, but we did and it worked, helped the country and indeed the world get out of the pandemic, and saved many lives.

31. I agree with the comments made in the Department's Module 4 Corporate statement that, *"the tools available in most pandemics and epidemics especially of respiratory pathogens, are testing, non-pharmaceutical interventions (NPIs), vaccines and therapeutics. All pandemics in recent history have been addressed by scientific understanding leading to pharmaceutical countermeasures, such as vaccines and treatments."*

32. It should also be noted that the CMO's Technical Report refers to discovering, developing and approving a new vaccine it has generally taken between 10 and 20 years. Also, as the report notes in developing a vaccine for SARS-CoV-2, there was an unwavering and unprecedented focus on expediting existing processes and creating agile alternatives in order to deliver a safe and efficacious vaccine to the population as soon as possible (MH6/6 – **INQ000203933**

33. By using data in a progressive, modern way, which, as set out above, included sharing data across the spine of the NHS, we developed the best clinical trial in the world (the RECOVERY trial for therapeutics), and also radically accelerated the clinical approval of the first vaccine in the world. Neither of these would have been possible without the most cutting-edge use of data from all reliable sources, and the insights from their operation are vital lessons both for the next pandemic, and the day-to-day operation of health and social care in the UK.

34. The clearest validation of the decision to take a strongly progressive approach to the use of data is the success of the vaccine programme. In all four elements of the vaccination programme: research; development; regulation; and rollout, we used cutting-edge data techniques, which helped make it the most successful in the world. Without a modern use of data that would not have happened. These lessons are vital for the next pandemic, and work is needed now to ensure we are as well prepared as possible to use data to save lives from the start. Furthermore, the vaccine rollout shows that the NHS can and should interact with patients using modern digital techniques, including for the basics like booking appointments and updating the patient record.

35. One example is the interaction of the vaccine companies with the regulator. Instead of data being generated by clinical trial, and then handed to the regulator for analysis and approval, the MHRA instigated a "rolling review", and ingested data from the trials as they happened. Another was the instigation of each phase of the trials immediately on completion of the previous phase.

Pre-pandemic preparedness: vaccines and therapeutics

36. As I set out in my witness statement for Module 1, during my time as Health Secretary I recognised the importance of vaccines and I led work on a 'Vaccine Strategy', including pushing for its publication to be brought forward (MH6/7 - INQ000184130; MH6/8 - INQ000184131; MH6/9 - INQ000184132; MH6/10 -

INQ000184133; MH6/11 - INQ000184134). Preparedness in this area was, in my view, 'prone to complacency' (MH6/12 - INQ000184122) and I felt particularly strongly about the need to combat the direct impact of disinformation from 'anti-vaxxers', where I had to overrule the relevant Departmental policy team (MH6/13 - INQ000184121; MH6/12 - INQ000184122) to put in place a more robust approach.

37. As I indicated in my witness statement for Module 1 (at paragraph 29, INQ000181825_008), As I was not in Government at the time of the 2011 strategy, I am unable to assist the Inquiry in identifying why so much focus was placed on preparing for an influenza pandemic, and to this extent I similarly cannot assist in what lessons were larned from vaccine development during the MERS, SARS-CoV-1 and Ebola epidemics, or the previous influenza and HIV pandemics. The technical advances in vaccine development following those diseases are questions the Inquiry should pose to those with the necessary technical expertise.

38. The Inquiry has asked why I considered that the Department's knowledge in early 2020 of medicine supply chains, including vaccines, was greater than at any time in modern history, as per paragraph 51 of my witness statement for Module 1. As I set out in that paragraph, the knowledge had been generated by work done in 2019 to prepare for a "no deal" Brexit, which had included consideration of the impact on pandemic preparedness (MH6/14 - INQ000184116; MH6/15 INQ000184117; MH6/16 - INQ000184118; MH6/17 - INQ000184119; MH6/18 - INQ000184120).

39. In terms of the outcome of my 2019 request for £200m to bring vaccine manufacture onshore, as I set out in my witness statement for Module 1 at paragraphs 83-84 (INQ000181825_0018-19), that request was made within the context of the Department's October 2019 submission to the Treasury for the 2019 Budget. As the Inquiry may be aware, the Autumn 2019 Budget was delayed due to Parliament voting to delay the UK's withdrawal from the European Union and

the then Government calling a General Election (MH6/19 - INQ000497971). The next Budget did not take place until March 2020, by which time the pandemic was already upon us. I cannot comment on the Vaccine Manufacturing Innovation Centre.

40. I am asked by the Inquiry for my response to the assertion by Kate Bingham and Tim Hames in 'The Long Shot' that *"...there was near-total ignorance in Whitehall as to what vaccine manufacturing actually entailed."* I would agree that much of the rest of Whitehall was not aware of what vaccine manufacturing actually entailed – although as they did not have direct responsibility for this it's hardly surprising - but the Department for Health and Social Care did have deep understanding and experience of vaccine manufacture from within. For example, the Chief Medical Officer was an epidemiologist and respected global expert, his Deputy, Professor Van-Tam had a background working with the pharmaceutical industry and long experience in vaccine manufacture and deployment, and as Secretary of Sate I had been working with officials on vaccine manufacture projects before the pandemic. The Department therefore had deep experience in vaccine manufacture and deployment, and made that available across Whitehall as needed, as the public would expect.

41. In terms of the questions the Inquiry poses about the preparedness of the UK for the rapid development of therapeutics to treat 'Disease X' in early 2020, this is obviously a difficult question to answer insofar as a therapeutic is necessarily the treatment of an existing disease (whereas prophylactics are preventative) and without knowledge of what the disease is, this cannot be planned for. However, it is apparent from the success of the RECOVERY trial that the UK was able to implement a world leading therapeutics trial with extraordinary pace. Whilst I strongly supported the establishment of the RECOVERY trial, and the implementation of those treatments such as dexamethasone that it identified, those such as Professor Horby and Professor Van-Tam deserve the credit for that remarkable achievement, and are better placed to answer questions about what it

and other initiatives drew from the development of therapeutics during the MERS, SARS-CoV-1 and Ebola epidemics and other previous influenza and HIV pandemics.

42. The Inquiry has asked about the work of the Covid-19 Antivirals and Therapeutics Taskforce. This body did not come into being until April 2022, after I had left my role as Health Secretary. However, I set up its predecessor bodies, the Therapeutics Taskforce in April 2020 and the Antivirals Taskforce in April 2021; both under Director General Clara Swinson. I was involved in their highly effective work.

43. To the extent that the Inquiry has asked whether I consider that the correct balance was struck between investment in the development of vaccines and investment in/the development of therapeutics, my answer is unequivocally 'yes'. We supported each with whatever resources were possible to deploy, and there was no trade off between the two in any way.

Emerging Reports of Covid-19 and Preparatory Decision Making

44. My first recollection of the virus is reading a news-in-brief story on New Year's Day about a mystery pneumonia outbreak in China. Reports of novel diseases are not in themselves that unusual, but I recall asking my Private Office to put together a briefing and I made a mental note to discuss it when back in the Department, which I did.

45. On 5 January there was more in the newspapers about the new disease in China, with fifty-nine people reported as infected, seven of whom were apparently seriously ill with breathing problems. There were also reports of concerns in Hong Kong and Singapore about the new virus, including a suspected case in a three-year-old Chinese girl who had recently been to Wuhan. I asked my Private Office for a full briefing on 6 January, which was to be my first day back in the Department after the Christmas recess.

46. On 6 January I had a meeting with the new CMO, Professor Chris Whitty, and his team to talk about mandatory flu jabs (MH6/20 - INQ000233736). I took advantage of having so many experts in the room to ask what was known about the new disease in China. I recall that the CMO and his team told me that they were across it but that there was not much to go on; he explained that they were trying to get whatever information they could out of the Chinese and the WHO. We talked about the chances of the virus coming here.

47. The CMO's view was that the Department needed to be vigilant, as it generally was in respect of monitoring novel infectious diseases. That notwithstanding I recall asking to see the emergency plans that were put together after the Whitehall pandemic preparation exercise known as Exercise Cygnus that had taken place a few years ago under my predecessor, Jeremy Hunt MP. I asked about the need for a vaccine, and options for its development. I was advised that creating a new vaccine takes many years. I recall being told that the work that had been done at Oxford University on an Ebola vaccine could be of value, and that in Professor Sir Jonathan Van-Tam we had one of the world's leading vaccine scientists as DCMO. Both these comments turned out to be prescient.

48. On 7 January I asked to speak to the CMO again about the new disease. Overnight it had emerged that the novel disease was not a strain of influenza but a coronavirus. My recollection is that the CMO explained that a new coronavirus was not good; the UK had stockpiles of flu antivirals, and I had signed off updating the pandemic flu vaccine supply plans in 2018 (MH6/21 - INQ000184107; MH6/22 - INQ000184108; MH6/23 - INQ000184109; MH6/24 - INQ000184110), but there was no vaccine against a coronavirus.

49. On 9 January I received my first written briefing about the virus from the Department in the form of an email to my Special Adviser ("SpAd"), Jamie Njoku-Goodwin (MH6/25 - **INQ000233737**). Given the limited information, not much was

known, but the plans for an influenza pandemic would have to be adjusted because the new virus appeared to have a much longer incubation period.

50. I learnt about the first death from Covid-19 in China on 11 January (MH6/26 - **INQ000233738** MH6/27 - INQ000182320). The victim had apparently died two days previously. The Chinese Government also published the genetic code of the virus. With the genetic code the work on developing tests for diagnosing the disease and the development of a vaccine could begin in earnest.

51. I met Sir Chris Wormald and the team to think through how the Department should handle what I wanted to be a very science-driven response, albeit with wider issues to consider.

52. At this point the response to the disease was still essentially within the remit of the Department, i.e., we were concerned with considering hospital capacity, nursing numbers, any legislative changes that might be needed, testing, the very early work on a vaccine, etc. I was, however, conscious that the rest of Government would be required to swing into action if the disease became more of a threat.

53. On 14 January I issued a statement about the benefits of modern vaccines and the dangers of listening to misleading information, to counteract misinformation being spread by Andrew Wakefield, the former doctor who got struck off for scaremongering over the measles, mumps and rubella vaccine. I did not want his ideas to be getting any public traction, particularly not at a time when a new vaccine for the novel coronavirus might be required. I was already worried about ensuring that vaccine take-up would be maximized, should one be needed for this novel disease.

54. During the afternoon I went to the CMO's office to discuss the latest developments; I recall that we discussed what was known about the virus and he stressed the importance of the R-number: the average number of secondary infections

produced by a single infected person, which determines how fast an infectious disease spreads. The CMO and I discussed a vaccine, with him outlining that there are effectively two types: ones that are pandemic-ending' and prevent people getting ill and passing on the virus; and the others that are pandemic-modifying', meaning it helps prevent illness but does not stop the disease in its tracks. The expert advice was that with something spreading as fast as it was in China, it was best not to count on eradication.

55. By 17 January there had been a second coronavirus death in Wuhan: a 69-year-old man. He had died two days before, but news of it had only just been made public. The USA had introduced health screening for arrivals from Wuhan at airports including San Francisco, New York and Los Angeles. I was uncomfortable about how little we were doing at the borders in the UK and raised it again with the PHE team. However, the clinical advice I received was very clear that action at the border would not make any significant difference. The CMO explained that he thought the virus had a 50:50 chance of escaping China. He further explained that if the virus got out of China in a big way it would likely 'go global'. Even with a low risk to any one person, a very large number of people would likely die. We discussed that a vaccine would be one route out of such a catastrophic pandemic.

56. On 25 January, I heard that Professor Robin Shattock from Imperial College London said that from the early vaccine work that he already had two candidates that would be ready to test on animals in the next month. The CMO was cautious, saying that the development of a successful vaccine could take years. I called for a meeting on Monday 27 January to go through everything. It seemed to me that vaccines were obviously the way out for all of us.

57. On 27 January, prior to the meeting starting at 09:45 through my Private Secretary I communicated my view to officials and the CMO that we should be working on a worst case scenario basis (MH6/28 - INQ000233743). At the 09:45 meeting I set out my view that we should instigate a travel ban from China. The response was

that this was an FCO matter. Dissatisfied with this I asked the CMO to talk to the FCO. The CMO is formally the adviser not just to the Health Secretary but to the whole Government, and so my view was that the FCO machine should listen to him. I also got an update on getting UK citizens out of Wuhan; it was thought that there were 200-300 there. I made it clear that my view was that anyone we bring back to the UK should go into quarantine. I received legal advice that any quarantine should be voluntary. I recall thinking that this was unacceptable. With officials we brainstormed solutions, and came up with the proposal that quarantining on return should be a condition of getting on the flight.

58. I also outlined my concern that I had heard that the virus was transmissible asymptomatically. The CMO reported that the global scientific consensus was still that asymptomatic transmission was unlikely. The CMO also indicated that the measures taken by China appeared to be having some effect and that the R-number was likely to fall. We also briefly discussed vaccine development and I indicated that we should pursue every option possible but the right officials were not in the room and so I called another meeting for the next day to go through it and what we could do to accelerate it (MH6/29 - INQ000106067).

59. On 28 January my senior team met in the early afternoon in my office to go through the reasonable worst-case. The CMO informed everyone that although there was currently no sustained transmission outside China, in the reasonable worst-case scenario as many as 820,000 people in the UK may die. Although the risk of death to each individual was low, the transmission was so high that almost everyone would catch it, in up to three waves, each lasting about fifteen weeks. I understood that we were looking at the risk of an epidemiological human catastrophe on a scale not seen in the UK for a century (MH6/5 - INQ000233747).

60. I asked what we needed to do to accelerate a vaccine. Professor Van-Tam explained that developing a vaccine normally takes five to ten years, but there was a team in Oxford working on an Ebola project that could be switched to the new

disease. He further indicated that if everything was fast-tracked, a vaccine could at best be developed in a year to eighteen months. I said that I wanted it by Christmas. Professor Van-Tam set out how the Department could fast track progress.

61. I called the Prime Minister on 29 January to provide him with an update, including of the worrying meeting about the reasonable worst case scenario the previous day. I found Prime Minister's Questions ("PMQs") on 29 January surreal: not a single question about the virus was asked. On reflection, this was perhaps unsurprising with the focus of the country on our impending departure from the EU and the current risk level still at low. I stood by the Speaker's chair thinking that every single question being asked would be irrelevant within a few weeks.

62. Following PMQs the CMO asked to see me, and proposed four elements for our response to the virus: first, we try to contain isolated outbreaks, then we try to delay the spread. If containment is unsuccessful and the virus spreads to the general population, we move on to mitigating and slowing its effects; and throughout we research for treatments and a vaccine. This led to my visit to Porton Down (the UK's Defence and Science Technology laboratory) to see its high-security testing and vaccine production capabilities.

63. On 31 January I spoke to the Prime Minister, and briefed Cabinet on the first cases, the reasonable worst-case scenario of 820,000 deaths, and the actions taken so far. 160. On 31 January I received a submission recommending we launch a rapid research call (through the National Institute of Health Research and in conjunction with the Medical Research Council), which was intended to strategically source, fund and manage research to better understand the disease and develop interventions to prevent, control and treat it (MH6/30 - INQ000057497). This call would also help to fund crucial vaccine research.

64. I wanted the UK to be first in the world to develop a vaccine. It was a huge ambition and at the time I could not be sure we could pull it off, but we threw everything at it. Given the scale of disaster set out in the reasonable worst-case scenario, I believed we would be justified in spending a huge amount of money to protect UK citizens. Around this time I spoke to Sajid Javid, the Chancellor, who agreed with this in principle. The Government pledged £20 million for the international research effort. I talked to the team again and emphasised the need to shorten every possible process, for example manufacturing before approval, and shortening approvals as much as possible subject to not lowering safety standards. Later modelling published in *The Lancet* suggests that Covid-19 vaccines prevented 14.4 million deaths around the world in December 2020-2021 alone (MH6/31 - INQ000497974). I supported Professor Van-Tam's recommendation that trials should be done in parallel, not in series, including beginning laboratory trials as soon as possible, then going straight onto Phase 1 clinical trials. Such an approach was unprecedented in the field of vaccine development.

65. I am asked by the Inquiry what specific safeguards were put in place to ensure that shortening approvals as much as possible did not lower safety standards and whether these were successful. The process of approvals was expedited as much as possible by the MHRA, but shortening that process (thereby reducing the timeframe for approvals) was possible because of highly effective data work, not the expense of safety. I consider that the expedition was necessary and hugely successful, as demonstrated by the UK having been the first country to approve and deploy a vaccine against Covid-19, and the widespread evidence that the vaccine saved so many lives.

66. I also had a call with the G7 nations on 3 February 2020, for which I received a briefing in advance (MH6/32 - INQ000233749). The briefing highlighted possible areas for discussion including: quarantine, a donor offer from the G7 to China, technical experts to support the WHO and/or China, face masks and PPE and travel advice. The briefing also noted that the Government had that day pledged

£20 million to develop new vaccines to combat new diseases and to advance a Covid-19 vaccine into clinical testing as quickly as possible, which we discussed.

67. I met with Jens Spahn, who was over from Germany, on 4 February; Germany was following our lead in giving more money to vaccine research. He asked whether we might do it together to show Germany and the UK cooperating post-Brexit.

68. On 5 February I had another meeting on the vaccine with the CMO, Professor Van-Tam, the Permanent Secretary and Lord Bethell, then the Department's Lords Whip, and as such a junior member of the Ministerial team, who I wanted involved in the vaccine mission.

69. I was provided with a submission on 7 February containing the latest information on the current state of research into coronaviruses and the likely costs and timelines of developing a vaccine for large scale testing in an outbreak setting (MH6/33 - INQ0002337511; MH6/34 - INQ000047660). I met the team to push further work on vaccine development. We went through everything we needed to do to get things moving as fast as possible. The CMO provided a reality check on how long it might take and the potential dire consequences of not doing everything by the book. Teams at the University of Oxford and Imperial College were already making great progress and I understood that the first trial doses should be available in a matter of weeks. My view was that the Government should get them manufacturing straight away so that if the trials came good, the country could vaccinate as fast as possible. I recognised that the pressure if and when a vaccine was found to work would be immense.

70. On Tuesday the next week, Professor Van-Tam told me that of the nine confirmed UK cases, the genome of seven had been sequenced. That meant that we had the genetic data to understand exactly what the virus was made of, which helped with testing, treatments and of course vaccine development. Various antiretrovirals, including Lopinavir and Ritonavir, were being trialled to see whether they could be

useful. Patients in China were being given an antimalarial drug called hydroxychloroquine, but there were no trial results of its effectiveness to justify its use. Professor Van-Tam and Professor Peter Horby at the University of Oxford were putting together a clinical trial called RECOVERY to test treatments for Covid-19 in hospitalised patients. Professor Van-Tam was very excited about and proud of how fast RECOVERY had been put together. My role as Health Secretary in these trials was to ensure that they were funded and to protect them from pressure to call the results before they were clinically valid.There was significant political pressure to declare the result of clinical trials before the results could be verified to a clinical standard of proof. For example, President Macron wanted to stop clinical trials and declare hydroxochloroquine effective whilst then President Trump sought to promote bleach. Some Members of Parliament and editors of press establishments were looking to declare victory on a treatment before clinical proof was established; I tried as much as I could to protect Professor Van-Tam and Professor Horby from such pressure.

71. By the third week of February, there was enough data from around the world for our experts to modify the worst-case scenario assumptions we had based on influenza. Professor Neil Ferguson from Imperial College gave an update on the four specific questions that the Government had asked him to look at: 1. What proportion of the population could be infected with coronavirus? 2. What proportion of those will develop symptoms? 3. What proportion of the symptomatic will need hospital care? 4. And how many will need respiratory support? His preliminary assumption was that 80 per cent of the population would get infected. Of those, 50 per cent would get sick, and, of those, 4 per cent would go to hospital for an average of six to ten days. He thought that a quarter of hospital patients could need ventilators, which would create a massive supply issue. NHS hospitals were not generally full of ventilators; normally only a small minority of patients have serious breathing problems. Professor Ferguson's estimated death rate was very tentative but could be around 2.5 per cent. All of his predictions were on the assumption that the Government did not take any mitigation measures and that there were no

treatments or vaccines, but the numbers still looked horrible. No matter how fast we accelerated the development of a vaccine, there was no hope that it would be ready in time.

The First Covid-19 Death in the UK

72. On 4 March, NHS England declared Covid-19 their highest grade of emergency, a Level 4 alert. This meant that Sir Simon Stevens took command of all health service resources in England. Sir Simon discussed this decision with me in advance and I was happy with it. Guidance for hospitals told them to assume they would need to look after Covid-19 cases in due course. In addition, a rule was introduced that everyone in intensive care with a respiratory infection must be tested for Covid-19. It was understood that there would be too many patients to treat on specialist Covid-19 units, so the Department had said that people could be cared for in wider infectious disease wards.

73. At this point SAGE had advised that we were around 4 weeks behind Italy on the epidemic curve. Italy indicated that they would close all schools and universities, while Germany declared an epidemic and shifted from containment to mitigation. There was of course no prospect of a vaccine to protect people over this timescale.

74. On 11 March the Chancellor set out his first Budget. Unlike other Departments, the Treasury do not need to agree policy across Government — they merely need to agree with No. 10. The Chancellor set aside £12 billion for fighting the virus, and made clear there was more to come. Crucially from my point of view, he promised the NHS would get whatever resources it needed to get us through the crisis. I took this to include any resources for vaccine deployment.

75. Early on 12 March the CMO called me to say that the country needed to raise the risk level from moderate to high. He also indicated that he thought the Government should move from the contain' phase to 'delay'. I understood that he had come to

these conclusions after discussions with his Scottish, Welsh and Northern Irish counterparts and they were all in agreement. The plan was to announce it at a press conference. The CMO was very straight with me and my team about what this meant: he explained that everyone was going to get infected and that the question was whether that happened before or after the vaccine had been developed. The decision to move to the delay phase was recorded in a protocol document (MH6/35 - INQ000049539) and announced by the PM at the press conference that evening.

76. A draft of the Department's "battleplan" was approved by the PM on 22 March 2020, and was broken into 7 key areas of work (which changed and developed over time), as listed below. I exhibit a copy of the various battleplans that were created during my tenure as Secretary of State as (MH6/36 - INQ000234336).

    a. Resilience (NHS and social care);
    b. Supply;
    c. Testing;
    d. Technology (which included new treatments and vaccines);
    e. Social distancing;
    f. Shielding; and
    g. Cross-cutting.

77. This demonstrates that while a vaccine was not going to be ready to help in the first wave, its development and deployment was a first order priority for the Department.

78. At the Covid-19 Strategy meeting on 24 March 2020, the PM agreed that the Department, the NHS and the MoD should work together to construct nine additional Nightingale Hospitals, to be made operational as soon as possible as it was recognised that the London surge was likely to be replicated across other cities in the UK (MH6/37 - INQ000056105). Although we hoped that this additional capacity would not be needed if the lockdown measures worked, both the high R

number (which was then between 2 and 3) and the high incidence of cases which had arrived much quicker than anticipated made it essential that we had additional capacity and contingency within the NHS to plan for the worst. In the end, the Nightingale hospital in London was used, and saved lives, but thankfully never reached capacity. The same strategy meeting also sought to accelerate the other essential limbs of our Covid-19 battleplan, including: PPE and ventilator supplies, raising a call for arms for private businesses to help us, ramping up testing, and beginning to investigate and trial treatments and vaccines.

79. Later that day I gave the daily televised briefing, launching the NHS Volunteers' Scheme. The scheme asked local communities to help those shielding, whether through deliveries, transport to medical appointments, or even a telephone call to anyone that was lonely or needed to be checked up on. We were aiming for 250,000 volunteers to join the scheme, but within a day over 405,000 volunteers had signed up. Like many other pivotal moments during the pandemic, the public demonstrated the lengths that they were willing to go to in order to help and look after others in the community. Throughout the pandemic I lost count of the number of times I was moved by the impressive, thoughtful acts of the British people.

80. Around this time, the updated data that Government had received from the NHS (MH6/38 - INQ000233783; MH6/39 - INQ000198014) predicted that the peak of the virus would be in April, and that our country would experience 65,000 deaths and 320,000 hospitalisations by September 2020. This was a reduced figure as a result of the restrictive measures that we had taken, and we were advised that if the restrictive measures were lifted after six months, then another, larger peak would take place later in the year, resulting in an additional 90,000 deaths. In my mind this reinforced the vital need for a vaccine to prevent this second peak.

Vaccines as the only safe exit plan

81. On 9 April 2020, I received the unofficial and unconfirmed results of a Government commissioned serology survey from Professor Van-Tam. The survey was intended to estimate the proportion of people who had previously contracted Covid-19, and would therefore give us an indication of the levels of immunity in society. The result was devastatingly low at 5%. Given the number of deaths already, this fact meant that the only viable strategy was to suppress the virus until the vaccine could deliver immunity safely to the population.

82. It was my view that we needed to suppress the virus, keep the R number below 1, until a vaccine could keep people safe. This would allow for, in time, a relaxation of the strict lockdown, recognising that we would need to be vigilant to rising case numbers. I discussed this view with the CMO the following morning, who had reached the same conclusion. He also highlighted that the winter and influenza season would have an impact on spread, NHS capacity and death rates. He said that that additional pressure suggested that Covid-19 was likely to be circulating in the UK and posing restrictions or pressures on society until at least Spring 2021.

83. On the 14 April, the First Secretary of State, the Chancellor, the Chancellor of the Duchy of Lancaster and I met to discuss our joint recommendation to the PM on the continuation of the restrictions, which had only been implemented for 3 weeks and therefore formally needed reviewing. I presented my view that the R number needed to remain below 1 until we had a vaccine, and that this should inform our approach to the relaxing or tightening of social restrictions both at that stage and going forward. After debating the issue, we made the decision to recommend that the formal lockdown continue for another 3 weeks, and to be re-assessed again at that time, by reference to five tests, which the Deputy Prime Minister announced: 1 — The NHS is able to provide enough critical care throughout the UK; 2 — A sustained and consistent fall in the daily death rate; 3 — Infection rates are falling to manageable levels; 4 — Testing capacity and PPE stocks are sufficient to meet

future demand; and 5 — Changes to restrictions would not risk a second peak of infections that would overwhelm the NHS. I regarded these tests as a useful framework for considering the factors around the decision.

84. I strongly supported the formation of the Vaccine Taskforce ('VTF') in April 2020. The VTF was intentionally imbued with a clear sense of independent authority, formally hosted by BEIS for pay and rations puposes, and reported to the Prime Minister and a Ministerial Board composed of the BEIS Secretary of State, the Chief Secretary to the Treasury, and me. It had a very specific set of aims focussed on one part of the vaccine project: procurement. Regulation and delivery were not its responsibility.

85. The formal aims of the VTF were: securing access for the UK population to a Covid-19 vaccine, supporting international access to vaccines, and leaving the legacy of a permanent UK vaccine and biotherapeutic capability, given the hard work that had gone into building these capabilities from scratch in response to the pandemic. I cannot recall whether there was any discussion about whether it should or should not include therapeutics, but the work on thereputics was being undertaken elsewhere at equally remarkable pace. I supported the formal reporting lines (which were not at any point moved), since I was on the three-person decision making Board, and both other Ministers were strongly supportive of the vaccine project. Crucially, both were willing to support projects that might not in the end come good, on the grounds that it was good value for money to back all potential candidates. The direct cost of vaccines had to be set against the colossal cost of the virus itself and the lockdown necessary to save lives. In practice it was clear that all major decisions relating to vaccines would be run past me informally in advance, which is exactly what happened throughout. I was provided with regular, at times daily, formal and informal updates on the progress of the Vaccine Taskforce. My focus was on ensuring that a vaccine was delivered as quickly and as safely as possible and that as many lives as possible were saved, which is precisely what we did.

86. I am asked why the Vaccine Taskforce was set up outside the standard departmental structure; quite simply this was because the development of a vaccine was clearly going to be a complicated essentially entrepreneurial undertaking of huge importance. The Chair and members of the Vaccine Taskforce were appointed for their expertise in tackling such a complicated and important problem. They needed a sense of freedom to drive hard at such an important mission, and I think the structure we devised did just that.

87. The Vaccine Taskforce was set up on the premise that we should accelerate vaccine procurement as much as possible, and hire in the best commercial negotiators to buy vaccines with a chance of being clinically proven from wherever we could find them. I strongly supported this approach, and offered to ensure Departmental funding was available to it. While over the period in question I had to sign various Ministerial Directions to ensure the money was spent, I regarded this a formality. For example, on 28 March 2020 the Permanent Secretary requested that I authorise the Department and its arms-length bodies be able to spend money on urgent Covid-19 issues, even if spending would be in excess of formal Departmental Expenditure Limits authorised by Parliament through the estimates process. I gave the Ministerial Direction as requested the very next day (MH6/40 - INQ000279919; MH6/41 - INQ000279920).

88. In my view, the successes of the Vaccine Taskforce include the fact that the UK was the first country to secure access to an approved vaccine and that the UK was the first country to start a vaccine booster study, the COV-BOOST trial, in May 2021.

89. Whilst I believe that the UK should maintain the ability to establish another 'vaccine taskforce' when the need next arises, I do not believe that there are improvements that can sensibly be made to its role. In my view its work stands as a testament to the power of public/private sector collaboration.

90. To this day I am immensely proud of the work the Vaccine Taskforce and the role that everyone at the Department played in its success as a member of the Ministerial Board overseeing its work. Put quite simply; its work saved countless lives.

91. On 22 April 2020, John Bell had messaged me to say the single dose efficacy of the Oxford vaccine on monkeys was amazing (MH6/42 - INQ000233802). This was very good news, and bolstered my belief that a vaccine would come good. The Oxford and Imperial vaccines were just two of the numerous vaccines that we were looking to buy in large scale from across the world. I did not expect them all to work — and many either failed trials or could not be manufactured at scale. But by this point I did expect at least one of them to come good. Unfortunately this view, despite being fully founded in the advice from Sir John Bell at Oxford University, did not prevail across Whitehall. I was astonished to find that the general No. 10 view - albeit not shared by the Prime Minister - was not to expect a vaccine to become available. This had two consequences. First, for those who did not accept that a vaccine was highly likely to come off, the cost of lockdown appeared permanent, not temporary, and therefore harder to justify. Second, those who did not believe a vaccine would happen focussed undue attention on using mass testing to control the virus. Mass testing reduced the impact of the virus and undoubtedly saved many lives, but was not on its own enough to keep people safe.

92. Professor Whitty gave a cautionary warning in the daily press conference on 22 April, when he advised that the chances of a vaccine within the next year were incredibly small, and that it was wholly unrealistic to expect life to return to normal any time soon, with social distancing restrictions likely to be in place for the rest of the year. Similarly, Ursula von der Leyen (President of the European Commission), had announced on 12 April that vulnerable individuals may need to isolate into 2021 or until a vaccine had been produced. I was more optimistic than either of these statements, but agreed it wise to set expectations cautiously.

93. I asked to speak directly to Sarah Gilbert, because I wanted to ask her if she needed anything else. I was frustrated to find that the money promised her had not yet been granted. She told me that Oxford's vaccine research required additional funding of approximately £22m, and that a funding request of a similar scale had been made by Imperial College in relation to its own vaccine research. I took action to ensure that both of these funding requests were prioritised (MH6/43 - INQ000233799; MH6/44 - INQ000233800; MH6/45 - INQ000233801). My view was that these sums were tiny compared to the lives a vaccine could save and the economic cost of lockdown that could be avoided, and even for the smallest chance of a vaccine working such sums should be paid. This demonstrates that normal processes for assessing funding, while often sensible in normal times, were the wrong approach in this crisis. I instructed the required funds to be paid. Thankfully, Oxford University themselves had been footing the bill until that point, and the first human trials of the Oxford vaccine began on 23 April. This episode demonstrates the need, in an emergency, sometimes to use taxpayers' resources in a faster way than normal, on a lower evidential base. This expenditure was some of the best value for money in history. If and when a vaccine was created it would then need to be produced at a large scale to guarantee its delivery not only to UK citizens, but to other countries around the world. Along with Oxford University, we were therefore taking steps to identify an appropriate manufacturing partner in advance to prevent delays to a vaccine roll out.

94. On 22 April I received a submission recommending that the Government liaise with Merck, an American pharmaceutical company that Oxford University had a long-standing arrangement with for the manufacture and commercialisation of Oxford's drug innovations (MH6/46 - INQ000233803).

95. I was concerned to read that a partnership with Merck would result in the UK only being able to "expect" access rights to the first batches of Covid-19 vaccines produced: this struck me as inadequate in circumstances where the British taxpayers were helping to fund the vaccine's development, it was legitimate to

have an agreement in place that ensured that the UK was given priority access to vaccines, and thereafter global access, rather than risking vaccines being sold to the highest bidder or otherwise restricted to domestic use elsewhere. I was keen to ensure as much onshore UK production as possible. I was very concerned about a scramble for vaccines once one was approved, and particularly concerned that the US might used their domestic legislation to require access to any vaccine produced. I therefore contacted Sir John Bell at Oxford University, and told him that I could not agree to the Merck agreement. Respecting the fact this was technically an Oxford University contract, not a Government contract, I asked that he look at alternative manufacturers. He readily agreed: (MH6/47 - INQ000233792).

96. My stipulation was that we needed legal agreement to exclusive access to the first 100 million doses. Subsequent discussions between Oxford University, the CSA and AstraZeneca resulted in the latter agreeing to manufacture the vaccine on the basis that the UK would be given exclusive access to the first vaccines produced onshore, and that AstraZeneca would collaborate with other countries to ensure production of the vaccine at cost, rather than for profit. Sir John Bell, Sir Patrick Vallance and Sir Pascal Soriot deserve significant praise for acting so quickly. Although AstraZeneca had originally proposed access to vaccines for 30 million people, I insisted that it should be for 100 million doses to cover all of the UK's population, with two doses, which AstraZeneca readily agreed to.

97. In late May 2020 I sought a meeting with the Permanent Secretary, the CMO and the DCMO on the use of challenge trials (deliberately infecting people with a disease in a carefully controlled environment for medical research purposes) for both vaccines and therapeutics (MH6/48 - INQ000480957). The meeting took place on 28 May 2020 (not February, as the readout suggests) (MH6/49 - INQ000480958; MH6/50 - INQ000480959). I was clear in the meeting that I did not want to dismiss the idea of challenge trials out of hand, needing an ethical framework to give the safest possible way of doing it, whilst still being effective.

The CMO was clear that the Government should not push such a trial, but that it should support such research if a study was approved by an ethics committee. I was keen to drive forward UK government involvement in principle.

98. Following a meeting attended by Departmental leaders with the CMO on 12 June 2020 (MH6/51 - INQ000233838; MH6/52 - INQ000233839; MH6/53 - INQ000233840; MH6/54 - INQ000233841). I decided that the Department should put in place plans for the reasonable worst case scenario of a second wave in winter. This was something that the CMO and I had discussed earlier in the year, but I was increasingly concerned that the Prime Minister wanted to move too fast on opening up, and that as a result R would go above 1. I repeatedly made the argument that until a vaccine arrived, there was no trade-off between economic considerations and health, because if R was above 1 that would inevitably lead to future lockdowns until a vaccine arrived. I found it baffling that this obvious logic had not been accepted across Government, and I was concerned that many parts of Government did not accept that the vaccine trials were progressing well and a vaccine looked promising.

99. Further on 12 June 2020, the Joint Committee on Vaccination and Immunisation ("JCVI") provided interim advice on priority groups for Covid-19 vaccination following an early commission for advice that I had made. This front loaded the work and ensured that the 'thinking' had been done about the sequence of deployment of any safe and effective vaccine once licensed for use in the UK. The prioritisation proposed by the JCVI was based on a clinical approach and, whilst later in the year in November other members of the Cabinet sought to argue for a different approach (for example, those from the Department for Education wanted the vaccine for teachers first, etc.), the clinical need approach was the one that was eventually adopted, supported by me, the then Chancellor of the Duchy of Lancaster, Michael Gove, and the then Chancellor, Rishi Sunak. The JCVI updated their advice on prioritisation as knowledge of the virus and the potential vaccines developed.

100. On 16 June 2020, the DCMO called me to report that the RECOVERY trial had revealed (tentatively, at least) that the common steroid dexamethasone could reduce the chances of a patient on a ventilator dying by around one third. Once its efficacy had been confirmed, within hours a Central Alerting System alert was issued that introduced a UK wide interim clinical access policy. Despite concerns from the Prime Minister's Chief of Staff, the country had been stockpiling dexamethasone and so there was no shortage of supply. I cannot stress enough how important the establishment of the RECOVERY trial was in aiding our battle against Covid-19; it was, I believe, the biggest and fastest pharmaceutical trial in UK history. Those involved in its creation and advancement deserve our thanks and the highest of plaudits.

101. Whilst the success of the RECOVERY trial should not be underestimated, therapeutics and antivirals were never going to stop the pandemic in the way that a vaccine could. That notwithstanding, whilst I was Secretary of State the Therapeutics Task Force and the Antivirals Task Force put up a number of business cases for procurement that were supported by me and other Ministers. I understand that the Department's Corporate Statement 4B sets these out in more detail.

102. On 19 June 2020, Alok Sharma, Steve Barclay and I formally signed off the plans to buy 100 million doses of the Oxford vaccine, the heads of terms having been agreed on 17 May 2020. I was heavily involved in the work to agree the Heads of Terms, including latterly in crucial, urgent work on the introduction of an indemnity – see for example (MH6/55 - INQ000485660; MH6/56 - INQ000485661), which I agreed, (MH6/57 - INQ000257379). As I have described elsewhere, the decision to order 100m doses was not without its difficulties. I met with significant resistance to the idea from some on the Vaccine Taskforce, who did not see the need to order so many, and wanted to order only for the most vulnerable. However, I was clear that if the vaccine worked, almost everyone would want or need it. The briefing I received for the meeting on 19 June 2020 shows an assumption of aiming to

vaccinate between 30m and 50m people in the UK (MH6/58 - INQ000401286). I insisted in the meeting that this decision was overturned, and as a result we bought for everyone.

103. On 25 June 2020 I was sent a note about the UK's potential participation in the EU Covid vaccine programme (MH6/59 - INQ000480970). The note invited me to text Jens Spahn, which I did, highlighting that the UK was talking to the EU Commission about joining up on potential EU procurement of vaccines. The point was made in the message that the UK faced a difficulty in that it might potentially mean losing deals that had already been done. My message sought a pragmatic way forward, but ultimately it was not possible to find one, as I would not agree to give up the deals that the UK had already made, whereas the European Commission made this a requirement of participation. Those deals we had already done put us ahead of the European Union in terms of securing vaccines, and my insistence on exclusivity in the contracts gave us a very strong position in the early procurement of vaccines.

104. I spent significant amounts of time addressing the issue of vaccine misinformation (or 'anti-vaxxers'). I had considerable experience in dealing with conspiracy theories online, from my time as Secretary of State for Digital, Culture, Media and Sport, and from my work against anti-vax conspiracy theories in relation to the measles, mumps and rubella (or MMR) jab before the pandemic (MH6/60 - INQ000485659). The Inquiry asks why I considered the Department's attitude towards tackling antivax sentiment in 2019 to have been 'complacent'. As I set out in the witness statement for Module 1 at paragraph 46, the UK had recently lost its 'measles-free' status, which I thought was appalling.

105. In July 2020, Lord Bethell shared some concerning research suggesting that as many as a fifth of people living in the UK would decline a vaccine. In terms of steps we took to counter vaccine disinformation/misinformation, we worked with the Cabinet Office Covid-19 Taskforce, which included members who had tackled

Daesh propaganda and developed a cross-Government strategy to put a counter-narrative to provide clear, objective and positive material about the vaccines.

106. We divided the population into five groups: the enthusiastic adopters; early adopters; the mass ranks; the hesitant; and the anti-vaxxers. The tactic was to avoid giving the anti-vaxxers the oxygen of publicity by ignoring them, to harness the enthusiasts, reassure the mass ranks and to persuade the hesitant to have the vaccine. I recognised that social media would have a huge role to play in countering misinformation, whilst playing a part as another medium through which disinformation/misinformation might be spread (by comparison, newspapers have historically spread misinformation about vaccines in the past, but they do so through the filter of their editor; with social media there is generally no filter). For example I contacted Nick Clegg, the former Deputy Prime Minister and then vice-president of global affairs and communications at Facebook. On 17 July 2020 I spoke to him about how Facebook might be able to assist; he indicated that he would do what he could to ensure that Facebook direct searches about vaccine safety to credible sources of information, including from the NHS. This did not result in a formal agreement, but this work tackling anti-vax conspiracy theories, including by the Cabinet Office Covid-19 Taskforce, was ongoing throughout.

107. The intention of asking the Department for Digital, Culture, Media and Sport to add "antivax" into the Online Harms White Paper was to formalise the responsibility of social media platforms in assisting to tackle the problem.

108. In terms of the wider messaging strategy adopted, this was developed by Cabinet Office, under the leadership of Alex Aiken, but I was engaged by my involvement in regular 'No. 10 briefings' at which we were always clear about the benefits vs. the disbenefits of Covid-19 vaccination. There were weekly 'comms' meetings that I participated in and specific vaccine 'comms' meetings once that became appropriate.

109. As regards public confidence in Covid-19 vaccines, I have set out above how we categorised those who were unenthusiastic or hesitant about the vaccines. I understand and respect hesitancy: wanting to be persuaded by the evidence before taking a vaccine. I cannot begin to fathom what would drive someone to propogate anti-vax conspiracy theories, against the available evidence. Generally my view was that the public increasingly trusted the vaccines that were developed due to their clear clinical benefit and life-saving properties.

110. There were many reasons for disparities in public confidence in vaccines. For example, in some communities it is statistically more likely that people have moved to the UK from a country with an authoritarian regime where the population has a lower level of trust in the government. In such circumstances, a member of that community might have greater scepticism of a vaccine produced and deployed by the state. In order to address such issues we: (i) produced communications in 'home' languages; (ii) delivered those communications via trusted messengers from that person's local community, for example, local faith leaders; and (iii) were thoughtful in use of the military in delivery.

111. Overall it is important to note that because of the considered, transparent and ultimately effective communications about the vaccine, the UK had one of the highest levels of trust in the Covid-19 vaccine (MH6/61 - INQ000497973). This is testament to the trust most people in the UK have in the health service, and the effectiveness of the communications programme overall.

112. Until the end of the transition period of the UK's withdrawal from the EU (31 December 2020), the UK would ordinarily have had to wait for the European Medicines Agency ("EMA") to approve a vaccine before looking to distribute it. However, the regulations allowed for the MHRA to issue a temporary authorisation. I agreed on 28 July 2020 to use regulation 174 to authorise a Covid-19 vaccine (MH6/62 - INQ000233916; MH6/63 - INQ000233917; MH6/64 - INQ000233918). I am asked by the Inquiry about the authorisation process for

vaccines and in particular the amendment to regulation 174; whilst others within the MHRA are better placed to assist the Inquiry with the general process of vaccine authorisation, the amendment to regulation 174 supported delivery at pace of a mass vaccination programme.

113. The Inquiry has asked a series of questions about 'Safety and regulation' that concern the role of the MHRA, including about the known risks associated with each Covid-19 vaccine. When it came to the approval of the Covid-19 vaccines, I trusted the MHRA's judgment as a hugely respected regulator, working based on the best possible use of data according to the scientific method. I also respected their independence and so was not involved in their day-to-day technical judgements. Nevertheless, the evidence is extremely powerful as to the effectiveness of the approved vaccines at protecting people and saving lives.

114. In my opinion, the MHRA was brilliantly led and I have no concerns about the safeguards that were in place to ensure the independence of it and its advisers. My perception is that, amongst those of the public who know of the MHRA, their confidence in it was extremely high.

115. In terms of the MHRA's Yellow Card monitoring and reporting system, I have no concerns about its operation, but I do consider that education about it might be improved. The problem is not, in my view, in the system itself but rather in a lack of knowledge about it. The challenge is in making sure that everyone knows about the Yellow Card system and uses it; ultimately it is an issue of data collection.

116. By 4 September 2020, further to advice I had received from the Department's Covid-19 Vaccines Team at the end of August 2020 (MH6/65 - INQ000233952; MH6/66 - INQ000233953); I agreed that we should focus our planning on two of the leading vaccine candidates, Oxford/AstraZeneca and Pfizer/BioNTech (MH6/67 - INQ000233978). This was reflected in a briefing I received (MH6/68 - INQ000480960), which set out that the Vaccine Deployment Programme Board had agreed, following guidance from the Vaccine Task Force, to focus

deployment of the two leading candidates (codenamed Projects Triumph and Ambush) because those were the only two that were anticipated as being deployable in 2020. At this stage there was a best-case deployment date of 19 October 2020, but this eventually slipped ironically due to the drop off in the number of cases of Covid-19, which had a knock-on impact on the speed at which trials could be conducted. As I set out below, I continued to push for the earliest possible best-case deployment date.

117. Also on 4 September 2020 I chaired the first of a series of weekly meetings (later daily) with the Permanent Secretary, David Williams, the DCMO, Kate Bingham and various senior Departmental, NHS, and Vaccine Taskforce officials to discuss deployment (MH6/69 - INQ000233979). At this meeting I pushed the team to start planning from a best-case scenario perspective and challenged the speed at which we would be vaccinating at scale. Consistent with the approach I took throughout my time as Health Secretary during the pandemic, I asked for a short note on the detail of modelling for the best-case scenario, and the plan to implement it, so that I could keep driving it forwards. I indicated that the Director of NHS Operations and Delivery, should take charge of the vaccine deployment project overall and report directly in to me.

118. While the timing was uncertain, by now the best case was a vaccine being approved at the start of December. In terms of bringing clarity to the timelines, I was told that as soon as the submission was made to MHRA for approval we should have a clear indication of when a vaccine would be approved. I decided to establish a Vaccine Deployment Delivery Board, which I would chair, to run rollout once the submission had been made to the MHRA. I pressed the team to plan for a best-case scenario perspective and challenged the speed at which we could be vaccinating at scale (MH6/69 - IN0000233979).

119. The Vaccine Deployment Delivery Board reported to me on a daily basis. My role in the roll-out procedure for vaccines was day-to-day operational leadership. Unlike the Vaccine Taskforce, delivery was not independent of Ministers. We in

turn reported to the Prime Minister weekly. The Delivery Board comprised the NHS vaccine delivery team (Emily Lawson) working with the Vaccine Taskforce, who worked on supply (led by Madelaine McTernan after Kate Bingham's departure). My aim was to maximise supply while always ensuring the NHS was able to deliver all the supply we could get.

120. In September I set 1 December 2020 as the reasonable best case scenario vaccine deployment date. I was advised the likelihood of having a vaccine ready to go by then was unlikely – but I was determined to ensure that if one was ready, the NHS would be ready to deploy. At this point Oxford University/AstraZeneca began submitting data to the MHRA under a rolling review process, enabling data to be reviewed in stage, as it became available (rather than the traditional approach of waiting until all of the data was available). This dramatically increased the effectiveness of the process and some two months later on 24 November 2020 Professor Sir Van-Tam was able to write to the Chief Executive of the MHRA to ask it to consider recommending temporary authorisation for the AstraZeneca vaccine (MH6/70 - INQ000059052).

121. In early September, fearing unhelpful interference from the Prime Minister's Chief of Staff and some officials in the Cabinet Office, I issued a direction that nothing about the vaccine rollout should go to No. 10 before first going through me. Preparations did not need central input at that stage, and this approach protected the team working on the rollout and to ensure that it was free from any of the problems at the centre. The revelations in Module 2 of this Inquiry of the poor levels of professionalism among Advisors and even some officials in the centre of Government, the depths of which I was not fully aware at the time, have demonstrated again with hindsight the importance of this decision. I kept the new Cabinet Secretary, CDL, and the Prime Minister up-to-date on developments directly, and they were fully supportive throughout.

122. The rollout was, unsurprisingly, a huge logistical challenge and its implementation required assistance from across Government. I engaged across Government to ensure we had all the support we needed. For example on 12 September 2020 I spoke with Ben Wallace, then Secretary of State for Defence, to request support from the armed forces for the vaccine rollout. He was unequivocably supportive. On 10 October 2020 I messaged Steve Barclay, then Chief Secretary to the Treasury, about financing the vaccine rollout and highlighted the importance of pushing it through fast; and he acted to ensure finance was always appropriately available.

123. On 22 September 2020, I called a COVID-O to discuss vaccine deployment (MH6/71 - INQ000234019; MH6/72 - INQ000234021). Together with the Secretary of State for BEIS I presented a paper on the progress of the work of the Vaccine Taskforce and set out the plans for deployment (MH6/73 - INQ000234020). I explained to the Committee that the Vaccine Taskforce would oversee the procurement and manufacturing of the vaccines through to regulatory approval by the MHRA, when responsibility would transfer over to the Department to handle deployment under the new Vaccine Deployment Delivery Board. Deployment would primarily be through the NHS with support from the military and local authorities. The Inquiry has asked why deployment was carried out by NHSE and not PHE; PHE was an executive agency of the Department, it did not have the capacity to lead deployment, whereas NHSE did. I confirmed to the Committee that the Treasury had expedited the financial approval process for the early expenditure required to put in place the logistical operations. I noted that the Oxford/AstraZeneca and BioNTech Pfizer were the two leading vaccine candidates for early deployment and, in the best-case scenario, these would first be available from December 2020, subject to successful completion of Phase 3 efficacy trails and regulatory approval for use (MH6/74 - INQ000090166).

124. Some participants in the discussion sought to limit the number of people who would receive the vaccine. The argument was made that we only needed to target

the clinically vulnerable. I had considered and rejected this argument on two grounds. First, that it was not clinically valid, as ending the pandemic required reducing the likelihood of someone passing on the disease as much as possible. Second, that the public wouldn't accept such a decision. I was also very concerned about the impact of long covid. Professor Sir Van-Tam made the point that it was up to the JCVI to recommend who got the vaccine and when, and then that the Government would make a decision based on its recommendation. (MH6/75 - INQ000165268).

125. On 6 October 2020 I attended one of the regular Vaccine Taskforce Ministerial Panel meetings. The minutes are useful in that they record the approach that I took (along with the Secretary of State for BEIS and the Chief Secretary to the Treasury) to back any vaccine in order to protect as many people as possible:

> *"The panel also discussed the risks around the Talent vaccine and that in a worst case scenario, were it to fail or be delayed, we would have a significant shortage of vaccine doses in the portfolio for early delivery next year. (The next suite of vaccines in the portfolio, Audacious and Astute, are due to provide first deliveries from Q3 next year.)*
>
> *Whilst recognising the relatively limited benefits and the commercial and deployment challenges of Renown, the Panel decided that, on balance, pursuing 5m Renown doses was worthwhile to ensure the Government had taken every opportunity to vaccinate the population, in particular those most vulnerable, in the event of a delay or failure to Talent. Continuing to pursue Renown could potentially mitigate risk and provide doses for a further 2.5m people in Q2 2021, slightly ahead of the next likely available vaccines which are due around the start of Q3."* (MH6/76 - INQ000479144)

126. The extract above provides an example of the approach that I, and the rest of my Ministerial colleagues, took, namely to take every opportunity to vaccine the population, and in particular those most vulnerable.

127. On 9 October 2020, I approved a submission for the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 to be laid before Parliament (MH6/77 - INQ000234075; MH6/78 - INQ000234078). The Regulations were made on 15 October 2020 and came into force on 17 October 2020. They amended Regulation 174 of the Human Medicines Regulations 2012, so as to enable conditions to be attached to the temporary authorisation of a Covid-19 vaccine by the MHRA, which render the authorisation as close as possible to that of a marketing authorisation under non-emergency routes.

128. On 6 November 2020 I met with the Cabinet Secretary to discuss detailed plans for the vaccine rollout (MH6/79 - INQ000480966; MH6/80 - INQ000480967). I had had various briefings/meetings in advance (for example on 3 November 2020, MH6/81 - INQ000480961; MH6/82 - INQ000480962, and 4 November 2020, MH6/83 - INQ000480963; MH6/84 - INQ000480964; MH6/85 - INQ000480965) and a meeting with the Devolved Administrations on 5 November 2020 (MH6/86 - INQ000279800) where I had outlined that the Barnett formula would be used for the allocation of the vaccines on a population basis in England and that I hoped that the Devolved Administrations would follow suit. I was grateful to each of my counterparts who agreed with the JCVI prioritisation in principle. I also took the opportunity in this meeting to highlight the work the Department had been doing on vaccine misinformation. The Cabinet Secretary approved the plans, and proposed they be presented to the Prime Minister the next week. I was hugely relieved. We had worked on the plans privately inside the Department, with the NHS, but not taken them to the Cabinet Office or No10 earlier due to my experience of the damaging interference in the Testing programme when the centre of government got involved. One reason the vaccine rollout was so successful was this clarity of leadership.

129. The Inquiry asks what I meant when in this meeting I indicated that the public should be made aware that vaccination was not a silver bullet but that it reduced their chances of Covid-19; I meant just that, i.e., vaccination was not a cure or

complete prevention, but that it would reduce their chance of catching the disease and decrease its severity if they did get it.

130. The work on vaccine deployment continued throughout early November and I was regularly sent updated copies of the draft strategy, e.g., (MH6/87 - INQ000480968; MH6/88 - INQ000480969).

131. On 10 November 2020 I announced that I had tasked the NHS to prepare and be ready for the vaccination programme to being from any date after 1 December 2020, reflecting my desire to meet the best-case scenario (MH6/89 - INQ000234617).

132. On 11 November 2020, I switched the vaccine deployment meetings to daily frequency. These were attended by DHSC, DCMO, BEIS and NHSE officials (MH6/90 - INQ000234158). Emily Lawson, as Head of the NHS Covid19 Vaccine Programme. From December 2020 Maddy McTernan, Director General of the Vaccine Taskforce, reported to me at these meetings. I exhibit, for example, the readout of the daily vaccine meeting on 7 December 2020 (MH6/91 - INQ000234207). We would then update the Prime Minister at weekly meetings as to progress. After he was appointed minister responsible for Covid-19 vaccine deployment at my suggestion on 28 November 2020, Nadhim Zahawi chaired the daily vaccine meeting if I was absent. He reported to me as a joint minister between the Department and BEIS (MH6/92 - INQ000234193).

133. On 13 November 2020, I attended a COVID-O to discuss vaccine development and deployment (MH6/93 - INQ000234149; MH6/94 - INQ000060716; MH6/95 - INQ000060717). I presented a paper on the interim JCVI recommendation on the priority groups for vaccination (MH6/96 - INQ000090908). I was determined that, before a vaccine was approved, we had to agree which groups should receive the vaccine in which order, and the reasoning had to be clearly communicated prior to the rollout. In anticipation of the need for an orderly and objectively

justified prioritisation, I had in the summer asked the JCVI to recommend a clinically based prioritisation, which they had published as interim advice on 25 September 2020. The interim advice, which I agreed with, set out that care home residents and should staff receive vaccines first, followed by people aged over 80 and health and social workers, before rolling out to the rest of the population in order of age and risk. The Committee agreed the recommendation in principle and for it to be put before the Prime Minister for a final decision, subject to further consideration by the DCMO and JCVI on prioritisation for the CEV cohort (MH6/97 - INQ000091132). This was important because I anticipated that many groups (teachers, police, even students) would demand the vaccine first, so I wanted an objective, clinically valid prioritisation from an authoritative source to ensure we were not blown off course by presentational or political pressure.

134. In summary, I commissioned JCVI for advice on the best way to save lives, given the vaccine supply position and the nature of the virus. JCVI provided the advice on prioritisation, and we implemented that prioritisation. While this was updated over time, it was clear that – aside from health and care workers because of their close interaction with the most vulnerable – a ranking by occupation would have led to more people dying. Despite many representations we therefore rejected that approach. I would strongly recommend following this approach for the future.

135. On 30 November 2020, the JCVI sent its final advice to the Department on the prioritisation for vaccination deployment of the Pfizer/BioNtech vaccine, which was broadly as above, but inserting the CEV cohort and adults age 18-65 at risk at appropriate level in the priority order. I was sent a submission that day seeking my agreement to rollout the vaccine in accordance with that prioritisation, which I provided (MH6/98 - INQ000234198; MH6/99 - INQ000234199). I arranged for a meeting with the Prime Minister the following day to update him on this, where he approved the publication of the JCVI's prioritisation list (MH6/100 - INQ000234202).

136. On 2 December 2020, the Pfizer-BioNTech vaccine gained regulatory approval from the MHRA under regulation 174 of the Human Medicines Regulations 2012, as amended. On the same day, the JCVI published its prioritisation list. I updated Parliament later that day.

137. On 8 December 2020, the University Hospital Coventry and Warwickshire NHS Trust administered the first Pfizer-BioNTech vaccine, which continued to be rolled out thereafter. This was the first clinically authorised vaccine against Covid-19 in the world. I was and I remain incredibly proud of the whole team who had delivered it.

138. The high-quality structure in place to deliver the vaccine made it possible to react quickly to circumstances, or new ideas. Above I have drawn out one such example as it is instructive, but there are many others.

139. In late December 2020, we decided to extend the vaccine dose interval to ensure that more people would be protected as soon as possible by getting the first dose, which offered 90% protection, than having to wait for two doses to be available at a closer interval, given the constrained supply. It is instructive to describe how this decision, which saved thousands of lives, came about. Special Advisers often get a bad press, but in this case, one of my brilliant team of Special Advisers was instrumental. When aligned with the mission Special Advisers are often good at challenging or breaking down groupthink. Damon Poole brought my attention to the idea which was set out in a tweet from an American epidemiologist, Professor Keith Klugman, on 17 December 2020 which said:

> *"First doses of Pfizer/Moderna vaccines are 90%+ effective after 14 days. Most high risk lives will be saved by giving all these limited early supplies of vaccine as first doses - second doses can be given later if first dose effectiveness wanes or when supply improves"* (MH6/101 - INQ000234239).

140. On 21 December 2020, I sought urgent advice on using a single dose of the Pfizer / BioNTech vaccine, and raised the idea of a longer dose interval with the CMO, who discussed it with the DCMO (MH6/102 - INQ000234251; MH6/103 - INQ000234252; MH6/104 - INQ000129637). The DCMO gave preliminary advice later that day that there was strong enough data on the protection provided by one dose to justify taking that approach and delaying the second dose interval (MH6/105 - INQ000153518; MH6/106 - INQ000153520). I judged that, so long as the policy had clinical approval from the CMO and DCMO, the public would accept the change. Following further investigation and discussion, the CMO and DCMO confirmed at a meeting I attended with the Prime Minister on 29 December 2020 that, from a clinical perspective, they were comfortable with the extension of the period between doses (MH6/107 - INQ000234268). Insofar as the CMO and DCMO provided advice that from a clinical perspective, they were comfortable, I would have expected them to have consulted colleagues in MHRA/JCVI if appropriate. Similarly, whilst I may have spoken to Dr Tedros Adhanom Ghebreyesus about the WHO's reporting of the matter, I relied on the clinical advice I was given by the CMO and DCMO.

141. This decision was backed by the Prime Minister. Over nine days over Christmas 2020 we lined up that clinical advice, prepared to change operational protocols and developed a communications strategy. On 30 December we announced the policy change. We dealt with criticism from those whose second dose was delayed, and from international companies and sceptical scientific voices. Later research estimated this change saved over 10,000 lives (MH6/4 - INQ000234331). It shows that no-one has a monopoly on good ideas.

142. Also on the 30 December 2020 1 met with my counterparts in the Devolved Administrations and agreed a 4 January 2021 start date for the roll out of the Oxford/AstraZeneca vaccine, which had just been approved by the MHRA. An announcement was made by the Joint Committee on Vaccination and

Immunisation later that day with advice on prioritisation of the first doses given by the four CMOs for the United Kingdom (MH6/108 - INQ000059401; MH6/109 - INQ000059403). A Written Ministerial Statement was also prepared to announce the approval (MH6/110 - INQ000059406).

143. On 3 January 2021 I spoke to the Prime Minister over the telephone about the worrying, rising numbers of cases. Based on these new data, I made it very clear that unless the country was placed into another lockdown, the NHS would be overwhelmed. Following extensive consideration over the next day, at 20:00 on 4 January 2021 the Prime Minister announced that England would be going into a national lockdown and that the public must stay at home, leaving only for those limited reasons permitted by law. Over the following fortnight I was extremely worried that even these measures might not be enough to control the spread and get R below 1. I worried that there was nothing more we could do in those circumstances, and that the NHS was already near breaking point. Thankfully, this full package of measures did control the spread and get R below 1, and so after 4 January we did not need to introduce any further restrictions. This was obviously a huge relief. We implemented a gradual step down from national lockdown, as the vaccination programme protected a greater and greater proportion of the population. It was an irony during this period that we were successfully rolling out the vaccine at the same time as having to deal with a second wave of infections that became bigger than the first.

144. On 5 January 2021 I attended a meeting chaired by the Prime Minister concerning vaccine deployment. I set out that there was an achievable, but challenging, target of offering a vaccine to the JCVI cohorts 1-4 by mid-February 2021 (MH6/111 - INQ000234275). I am asked by the Inquiry as to supply issues in 2021; quite simply, we did not have enough supply to meet the demand. The goal was always to supply enough vaccines to beat the rate at which the NHS could administer them; supply of vaccine was the rate-limiting factor, and the NHS rollout was currently able to deliver all the vaccine that we expected to receive. I

also attended a meeting with the Prime Minister to discuss NHS capacity at which I outlined that the NHS in London, the South East and the East of England were already approaching the limit of their capacity to treat Covid-19 and non-Covid-19 patients (MH6/112 - INQ000059480). Various actions were agreed in order to support the NHS in those areas and to try and avoid it being overwhelmed.

145. On 6 January 2021 I tabled a written statement in Parliament concerning the contingent liabilities arising from the contract between the Government and AstraZeneca/Oxford in respect of the vaccine (MH6/113 - INQ000234274). Given the exceptional circumstances of the pandemic, this required taking a broader approach to indemnification than the Government usually would, because it would have been unreasonable for AstraZeneca to shoulder the risks indemnified, not least as they had chosen not to profit from the vaccine. There is no sense in which indemnification implies that the vaccine was anything but life-saving.

146. Because AstraZeneca had agreed to manufacture the vaccine without taking any profit, it was entirely understandable they could not justify the financial liability of not being indemnified. That could only be shouldered by the state, hence the reference in the written statement to Parliament that the Government was taking a broader approach to indemnification than it usually would.

147. On 7 January 2021 I attended a further meeting with the Prime Minister and others about the vaccine rollout. The meeting focussed on how the vaccine rollout would be delivered across the country and building trust in it (MH6/114 - INQ000234278). I continued to manage the vaccine rollout on a day-to-day basis, including through a daily call with all of the key responsible officials. We updated the Prime Minister, generally weekly, and he gave his steers, which were essentially to try to go faster. We occasionally asked the Prime Minister to make calls to key international players, like the Chief Executives of the major vaccine

manufacturers, which were helpful. My perception was that they were helpful in ensuring the smooth delivery of vaccines, and therefore the continued rollout.

148. On 8 January 2021 I was provided with an information only submission concerning the interim readout from RECOVERY AND REMAP CAP trials concerning convalescent plasma (MH6/115 — INQ000059533).

149. On 18 January 2021 I chaired a meeting concerning a potential new Covid-19 variant in Liverpool, noting that the Department must do everything possible in response to new variants (MH6/116 - INQ000234282), which were a significant concern given that we did not yet know whether the vaccine would be effective against emerging variants. Now that we had two vaccines that worked against Covid-19, the major remaining concern was of a variant that was resistant to the vaccine, as this would have sent us back to the start and risked disaster.

150. Whilst the Government was accelerating the rollout of the vaccine towards the end of January 2021, the EU sought to frustrate this by seeking to impose an export control that would have hampered the UK's ability to take delivery of doses the Government had already purchased. EU leaders were frustrated that we had put in place legally binding contracts to secure early vaccine doses for the whole UK population, and sought to use all possible legal powers to divert vaccines into the EU. This row took up a huge amount of time and effort over the forthcoming months, and involved a wide range of Government actors to defend our position, see for example the note of a meeting on 27 January 2021 (MH6/117 - INQ000497972). The UK was in a strong position because we had secured early access to 367 million vaccine doses through agreements with seven separate vaccine developers and had rapidly scaled domestic capacity, for example the bulk of the AstraZeneca vaccines for the UK were being made in Oxfordshire and Staffordshire, with filling into vials taking place in North Wales, and we had good security of the Pfizer supply chain, which were the first vaccines we deployed. Thankfully, the EU eventually backed down. The lesson from this whole ugly

episode is the vital importance of exclusive contracts for delivery, and as much onshore manufacture of vaccine as possible. Although it was uncomfortable that the EU attempted to act in this manner, thankfully, we had been attuned to this from the start, and I had insisted the contracts we put in place protected UK supply as much as possible, but naturally any limitations on supply had consequences for our ability to deploy vaccines.

151. On the night of 27 January 2021 I did a night shift at Basildon Hospital alongside NHS staff. It was an extraordinarily sobering experience. I have described before the incredibly impactful experience of seeing a patient with Covid-19 consent to being intubated in the knowledge that his chances of waking up were 50/50. This drove home to me once more the horror of the pandemic.

152. On 29 January 2021, ahead of a meeting with the Prime Minister on the same day, I had a meeting with Departmental officials to discuss the exit strategy from lockdown, as by that point the restrictions, combined with the vaccination programme, was starting to drive case numbers down (MH6/118 - INQ000234284). At the COVID-S meeting chaired by the Prime Minister a draft document on the 'Strategy and Pace of De-escalation' was discussed (MH6/119 - INQ000234283). I argued that we needed to exit lockdown at a pace that was as fast as reasonably possible, subject to there being no reversals. We should always keep R below 1, increasingly relying on the vaccine to suppress the virus. I also argued England should move at one pace and we should not revert to the tiers system. Both these points were agreed. It was rewarding to see that the number of cases was falling faster among vaccinated cohorts, demonstrating that the vaccine was working in practice.

153. On 3 February 2021 the Department announced that more than 10 million people in the UK had received one dose of a vaccine against Covid-19, with those doses being delivered between 8 December 2020 and 2 February 2021. 9 out of 10

people aged 75 and over in England had had their first dose. As I said at the time, and by which I resolutely stand now:

> *"This terrific achievement is testament to the monumental effort of NHS workers, volunteers and the armed forces who have been working tirelessly in every corner of the UK to deliver the largest vaccination programme in our history. Every jab makes us all a bit safer— I want to thank everyone for playing their part.*
>
> *Vaccines are the way out of this pandemic. The unprecedented national effort we have seen right across the United Kingdom means the majority of our most vulnerable people are now inoculated against this awful disease.*
>
> *The UK government has worked rapidly to secure and deliver doses to all of the UK, demonstrating the strength of our union and what we can achieve together."*

154. On 9 February 2021 I gave an oral statement to the House of Commons concerning the work that I had been leading on with the Department, the Home Office and the Department for Transport on strengthening our health protection at the border. I set out the three elements of the strengthened end-to-end system for international arrivals, which was due to come into force on 15 February 2021 (MH6/120 – INQ000234286): hotel quarantine for UK and Irish citizens who had visited a red list country in the last 10 days and home quarantine for all passengers from any other country; strengthened testing with a three-test regime for all arrivals; and strong enforcement. I won the argument for the stronger border policy because of the reasonable fear of a variant that might undermine the success of the vaccine programme.

155. On the morning of 15 February 2021 I attended a COVID-O meeting chaired by the Prime Minister to discuss the proposed approach to regular testing in school

environments as a pivotal part of the first step in the roadmap out of the third lockdown, which was in the process of being discussed and finalised (MH6/121 - INQ000091747; MH6/122 - INQ000092358; MH6/123 - INQ000092359; MH6/124 - INQ000234289).

156. Almost immediately after this meeting I chaired a meeting with Departmental officials to discuss the details of the roadmap (MH6/125 - INQ000234299), following a submission I had received on the Departmental position on the various elements of the roadmap the day before (MH6/126 - INQ000234297; MH6/127 - INQ000234298). I was clear in this meeting that any reopening should be *"...driven by the data, not dates."*, which in my view had not been the case during the reopening in Summer 2020 and led to us re-opening too far, resulting in exponential spread of Covid-19 and the second wave. Five steps were proposed in the Roadmap (starting with returning children to education settings as a priority) assessed against four 'tests':

a. The vaccine deployment programme continuing successfully;
b. Evidence showing that vaccines were sufficiently effective in reducing hospitalisations and deaths in those vaccinated;
c. Infection rates not risking a surge in hospitalisations which would put unsustainable pressure on the NHS; and
d. The assessment of the risks not being fundamentally changed by new Variants of Concern.

157. On 18 February, I then met with the Prime Minister, the Chancellor of the Duchy of Lancaster, the CMO, Baroness Dido Harding and Steve Barclay to discuss the schools testing plan, as well as plans to regularly test employees who returned to work as part of the roadmap: (MH6/128 - INQ000234306). The Prime Minister agreed with our proposals, and also requested proposals on how the certification of vaccines and testing could be used to assist with opening risky sectors and venues, which he considered needed to be addressed in the roadmap.

158. Later on 18 February, I held a further meeting with senior officials in the Department to discuss the thinking that had developed on how we would approach some of the finer details of the roadmap out of the third lockdown (MH6/129 - INQ000234300). We were anticipating that any easing of social restrictions prior to the Easter weekend would only apply to outdoor interactions, which we had been advised by the CMO carried a lower risk of transmission. We discussed how the five tests for easing restrictions might be met in the coming months, noting that some restrictions (particularly international travel) may need to kept in place, subject to the current data on variants of concern and vaccines.

159. As I explained in this meeting, it was imperative that the roadmap was guided by the scientific advice on whether or not the vaccines were effective against variants of concern. Not only was this consistent with the stipulation that we would follow 'data not dates', but it was central to our agreed strategy: the vaccines were our route out of lockdown because they lowered Covid-19 deaths significantly. If they were not effective against variants of concern, the justification for easing restrictions disappeared entirely. I was particularly concerned about the widespread expectation that international travel would be resumed as part of the roadmap: this would inevitably expose the country to a number of new variants. Unless the scientific advice was that the vaccines were effective against developing variants, the risk of reopening too quickly was unacceptably high levels of Covid-19 hospitalisations and deaths. I said publicly around this point that I expected us to have a "great British summer" but that we could not expect international travel to have returned to normal.

160. Alongside vaccines, testing was another critical plank of the easing of restrictions. Although it was hoped that the vaccines would significantly reduce Covid-19 rates, it remained pivotal that we identified positive cases and restricted their spread, and that we had the best possible information on variants of concern, which were detected through PCR tests with genomic analysis. Our testing

capacity had continued to increase, and we were able to offer regular testing to the entire symptomatic population.

161. Following the first vaccination on 8 December 2020, the vaccination programme had moved at an astonishing pace, with 15 million first doses and half a million second doses having been given to adults in England as of 22 February 2021 when the Roadmap was agreed.

162. In October 2020, the Serum Institute of India ("SII") had approached the Department to offer 10 million doses of the Oxford/AstraZeneca vaccine, which they had manufactured in India. The SII were grateful for the UK's approach of allowing them to manufacture the vaccine at cost. This would have been subject to the approval of the MHRA and receiving confirmation that India would permit the exports of the vaccines after they had been purchased. I asked the Department to take this offer forward, but unfortunately, the Vaccine Taskforce did not proceed with this proposal at the time, stating that the MHRA's approval would not arrive in time for the vaccines to be used.

163. However, the SII continued to offer vaccines. They maintained their argument that without the exceptionally generous Oxford/AstraZeneca agreement to allow manufacture of the vaccine at cost around the world, they would not have been able to make vaccine for India and many African countries at all. In February 2021, this offer was brought to the Prime Minister's attention, and he asked why it had not been taken up.

164. Upon investigation, it became clear that the members of the Vaccine Taskforce had in fact blocked the Department's proposal because they did not approve of purchasing vaccines from India, on the mistaken assumption that the UK was 'taking' vaccines from a lower income country that needed the vaccines (MH6/130 - INQ000095800; MH6/131 - INQ000129723; MH6/132 - INQ000129725). This was not accurate: the SII was a significant manufacturer of vaccines, producing

50 million doses per month which were shipped worldwide. In receiving 10 million vaccines from the SII, the UK was purchasing vaccines that had been intended for worldwide sale, not for deployment within India. In fact this was reflected in the contract with AstraZeneca, which explicitly required AstraZeneca to warrant that any supply from SII would not prevent SII satisfying the supply of vaccines to India and other low to middle income countries.

165. The Oxford/AstraZeneca contract is one of the most generous contracts ever written. The Inquiry asks why I consider it was one of the most generous contracts ever written: unlike most of the other vaccine manufacturers, AstraZeneca did not charge for the intellectual property, and during the pandemic, allowed for the vaccine's manufacture at cost. They could have made billions from sales, and chose not to. Personally, I was frustrated that we as a country did not make more of this generosity. Debates around this time about "donating" small number of vaccine doses entirely missed the point that AstraZeneca was donating the ability of most of the world to manufacture the vaccine. Later debates pushed by the White House promoting banning charging for IP for vaccines for the developing world missed the point that the UK had done this from the start through this remarkable contract. Accepting a small number of doses, essentially in thanks for and recognition of this enormous generosity, was entirely reasonable. AstraZeneca should be showered with praise for their role in helping protect more people around the world than anyone else; this is what I mean by suggesting that the UK did not make enough of this generosity.

166. It was disappointing that this proposal had not been proceeded with in October 2020, and that the objection had not been explained in full so that it could be aired and resolved. Had the proposal been accepted at that stage, we would have received 10 million doses at a much earlier date, which would have propelled the vaccine rollout significantly which could, in turn, have saved more lives.

167. Having straightened all this out, at a meeting on 19 February 2021 (MH6/133 - INQ000234302) the Prime Minister approved the SII proposal, on the basis that the 10 million doses fell within the 100 million doses that the UK had contracted from AstraZeneca. On 21 February we were able to announce that all adults would be offered a Covid-19 vaccination by the end of July.

168. At the same time, we were continuing to work hard towards our commitments under the WHO's COVAX programme, and on 24 February 600,000 doses of the Oxford/AstraZeneca vaccine arrived in Ghana, which was the first batch of COVAX vaccines to be delivered outside of India under the programme, marking the start of the first wave of billions of vaccine deliveries to COVAX recipient countries. The UK was a significant contributor to the programme directly, and contributed tens of million of vaccines to the programme, on top of the supply of billions of doses of vaccine at cost due to the AstraZeneca contract.

169. Throughout 2021, many of the large pharmaceutical companies were accused of 'pandemic profiteering', by selling vaccines for profits when much of the developing world did not have access to vaccines. In my view, Oxford University and AstraZeneca have not received enough credit for their role in ensuring worldwide access to the vaccine by delivering the Oxford/AstraZeneca vaccine at cost during the pandemic, enabling orders to go further and therefore protecting a larger proportion of the world's population.

170. By 25 February 2021, we had administered 18 million doses of the vaccine across the UK, and it was anticipated that the JCVI's priority cohorts 1-9 would be vaccinated by mid-April. We had requested advice from the JCVI as to how the remaining population should be prioritised for vaccination to prevent as many deaths and hospitalisations as possible. The interim advice received by the JCVI as of 25 February was that the most effective approach was to offer vaccines in age bands, as age was one of the biggest contributing factors to the development of severe Covid-19 (MH6/134 - INQ000091751).

171. I asked the JCVI to consider that the data showed an increased risk of hospitalisations among men, BAME communities, those with a BMI of 30 or more (who were therefore classified as obese or morbidly obese) and those who were considered to have socioeconomic deprivation. The JCVI considered these facts, and nonetheless found that based on an objective analysis their prioritisation was right, and for those groups it recommended encouraging uptake insofar as possible (MH6/135 - INQ000234304; MH6/136 - INQ000305136; MH6/137 - INQ000234305).

172. We agreed to adopt the interim recommendations of the JCVI which I announced at the daily press conference that day, on the basis that we needed to be guided by scientific advice as to how we could save as many lives as possible.

173. The JCVI's advice was confirmed as final on 12 April 2021: (MH6/138 - INQ000234313; MH6/139 - INQ000111698).

174. On 8 April 2021, PHE announced that it estimated that the vaccination programme had prevented 10,400 deaths in the UK (MH6/140 - INQ000234312). Subsequently, oy 27 April (when 1 in 4 UK adults had been vaccinated), the number of deaths involving Covid-19 had fallen by an astonishing 97% since the peak of the second wave; the vaccine's development and rapid roll out had fundamentally improved the consequences of contracting Covid-19 for the vast majority of the population, and was a true British success story.

175. Due to the success of the vaccine rollout we were able to move to Step 2 of the roadmap as of 12 April 2021, which enabled the re-opening of all non-essential retail and outdoor venues. A Cabinet Office review was prepared for COVID-O prior to the decision and we agreed that the country was ready for the move to Step 2, noting that nearly half of the adult population had received their first dose (over 30 million doses) (MH6/141 - INQ000091824; MH6/142 - INQ000091825; MH6/143 - INQ000092027; MH6/144 - INQ000091855; MH6/145 -

INQ000091856). The scientific advice that we were receiving at that time suggested that the vaccine provided 60% protection against contracting Covid-19, 80% protection against being hospitalised as a result of contracting Covid-19, and up to 85% protection against death due to Covid-19. It was therefore highly likely that Covid-19 rates would go up (among the unvaccinated but also, to some degree, the vaccinated) but that we would not see an accompanying sharp rise in hospitalisations and deaths.

176. Cognisant of the likely time-limited protection of the vaccine, and the need to ensure that protection was adequate in the winter months, we had also been preparing plans for a vaccine booster programme, beginning in the Autumn. On 20 April I attended a meeting with the Prime Minister and the CMO to discuss these plans, including how and when they would best be delivered, as well as the nature of the vaccine to be delivered in a booster programme (MH6/146 - INQ000234315). This resulted in agreement in principle to begin booster jabs in September 2021, and I put in place a series of further meetings to plan the booster rollout.

177. Following the easing of restrictions on 12 April 2021, we had been keeping a close eye on Covid-19 data to assess the impact of the easing and whether it was likely to be possible to move toward Step 3. As of 28 April, 33 million UK adults had received their first dose and 13 million had received their second dose of the vaccine, which meant that a significant proportion of the most vulnerable adults had the enhanced protection that the second dose offered.

178. In COVID-O discussions as to whether or not the UK was prepared for Step 3 of the roadmap, we noted that the next step would inevitably pose challenges to social distancing given the higher limit on gatherings, and as venues and public transport got busier. This would inevitably result in increased transmission, and an increased demand on the test and trace programme. By this stage, the country's PCR testing capacity was 635,000 tests per day, and in addition to the

now very widely available LFT tests had expanded to a level which meant that we could offer asymptomatic testing as a preventative and mitigating measure for the increased risk associated with Step 3 of the roadmap. Furthermore, the overall prevalence of Covid-19 across the UK was less than 0.1%, which we considered to justify proceeding with the move to Step 3 as planned (MH6/147 - INQ000091881; MH6/148 - INQ000091924; MH6/149 - INQ000092126; MH6/150 - INQ000092458; MH6/151 - INQ000091903; MH6/152 - INQ000091902; MH6/153 - INQ000092063; MH6/154 - INQ000092474).

179. Although the overall prevalence of Covid-19 was less than 0.1%, there remained areas of concern where cases were being reported at enduring transmission levels which were out of keeping with the national average. We were advised that these were high risk areas because they were, broadly speaking, populated by groups who were particularly susceptible to the risks of Covid-19, and among whom vaccine uptake was particularly low. This was a difficult problem to solve: we could not force anyone to have the vaccine, but it was a big concern that individuals in these areas could be badly affected by Covid-19, particularly if a virulent variant of concern emerged. We agreed that further work would be undertaken to try and encourage vaccine uptake in these areas, which would need to be led by a proper understanding of why vaccine uptake was low, and any concerns that were held. I delegated that further work to Nadhim Zahawi.

180. Since March, much consideration had been given to the resumption of international travel which, for the reasons set out above, posed particular risks. In tandem, further consideration had been given to the role that vaccine and/or testing certification could play in the UK's reopening and in relation to international travel. As part of Step 3, it was announced that international travel would resume on 17 May, and that the NHS App would facilitate an NHS Covid Pass for the purpose of demonstrating vaccination status for travelling. I discuss decision making in relation to international travel in further detail below.

181. On 10 May, the day that the Prime Minister announced that the country would move to Step 3 of the roadmap on 17 May, deaths and hospitalisations due to Covid-19 were at the lowest levels since July 2020 thanks to the impact and rapid roll out of the vaccine.

182. As was to be expected with the easing of restrictions, Covid-19 cases began to rise in mid to late May 2021. However, the relationship from cases to hospitalisations and deaths, which had remained constant throughout 2020, was now much weaker, thanks to the vaccine. As is now widely known, it is possible to catch Covid-19 after a vaccine, but the disease is usually much milder. It became clear that a large number (between half and three quarters) of new cases were of the Delta variant, a new variant of concern which was first identified in India in October 2020. Not only was the Delta variant of concern because it was associated with rapid transmission, the scientific advice that we had received was that the Delta variant was to some degree resistant to one dose of the vaccine. However, thankfully, protection against Delta increased significantly following the second dose of the vaccine. Without this assurance we would have had a much bigger problem, as a vaccine-resistant variant would have risked all the progress that had been made on safely opening up.

183. The delivery of the vaccination programme therefore remained a pressing priority (MH6/155 - INQ000234317). We also agreed to conduct surge testing and surge vaccination in eligible cohorts within areas that had the highest rates, particularly the North West of England (MH6/156 - INQ000234316). We resisted calls to allow a wider group access to the vaccine in these areas, having seen how local lockdowns had caused problems of fairness, but we did put extra resources in to help ensure as high a proportion of those eligible got the vaccine as fast as possible. We put in place significant resources to ensure vaccine adoption was as high as possible across all communities. By the end of May 2021, cases of the Delta variant were growing exponentially, which resulted in Government's consideration of whether it was acceptable to progress to Step 4 of the roadmap:

we could not risk cases spiralling out of control as they had done after the first lockdown.

184. I am asked by the Inquiry what the background to surge vaccination was in particular geographical areas (and particular the North West of England in May 2021). There was a debate about vaccinating in surge areas and the advice clear was to make more vaccines available within the area, rather than opening up vaccination to other groups, to save most lives.

185. SPI-M concluded that the Delta variant had a 40-60% growth advantage over the Alpha variant (MH6/157 – INQ000234319), and on 4 June 2021 I was provided with a risk assessment (MH6/158 – INQ000234320) which explained that early evidence indicated an increased risk of hospitalisation from the Delta variant, and that around 20% of the Delta cases were people who had received only one dose of the vaccination (as compared to those who had received two doses, who made up 3% of the cases).

186. A delay to the roadmap was far from desirable given the prolonged impact of the restrictions on society, particularly on a number of groups with specific vulnerabilities and known disadvantages, including: disabled people, BAME groups, and those on a lower income, of whom women and young people made up a greater percentage. We considered the decision very carefully and noted these impacts. We were presented with evidence that a relatively short delay of 4 weeks would save many thousands of lives, because the delay would enable us to deliver more vaccines: all adults would have been offered their first dose by 19 July, and all over 40s would have had their second dose, which was an important protective factor against severe Covid-19 infections and hospitalisations. Not only had we committed to making sustainable and irreversible changes to restrictions, the entire roadmap plan was founded on the protection of the vaccine and therefore had to reflect the rollout and the data on vaccine efficacy against variants of concern. This delay was discussed at a Quad

meeting on 13 June, and then at the COVID-O meeting on 14 June (MH6/159 - INQ000146807; MH6/160 - INQ000234322; MH6/161 - INQ000234323; MH6/162 - INQ000234325; MH6/163 - INQ000092509).

187. By 18 June, vaccine bookings were open to all adults. As of 18 July, a day before the easing of the final remaining Covid-19 restrictions, every adult had been offered a first dose of their Covid-19 vaccine, 87.9% of adults had received their first dose, and 68.5% had received their second dose (MH6/164 - INQ000234326). We had achieved a phenomenal amount as a country in the seven months since the first patient received a Covid-19 vaccine on 8 December 2020 and since the MHRA approved the Oxford/AstraZeneca vaccine on 30 December 2020.

The Vaccine Roll-out and Care Homes

188. As part of the cautious easing of restrictions under the roadmap, it was decided that care home residents would be able to receive a regular indoor visit from one named individual as of 8 March, in addition to the existing pod, screen, or outdoor visits (MH6/165 - INQ000234301; MH6/166 - INQ000091741; MH6/167 - INQ000091745). A resident's named visitor was required to take a Covid-19 test before entering the care home, and had to follow certain rules and protocols to ensure that the visits did not pose a threat to the safety of the residents.

189. During the easing of restrictions it had been identified that there had been a low uptake of vaccines by social care workers, with the percentages of workers and residents who had received the vaccine reported as being below the targets which had been set by SAGE to keep the R number below 1 and prevent spread in care homes. This was a matter of extreme concern given the vulnerable people that those carers worked with, and the proven impact of the vaccine on both transmissibility and the severity of Covid-19 cases. The data on the Delta variant only exacerbated those concerns.

190. The Prime Minister and I had therefore discussed making flu and Covid-19 vaccinations a condition of work for all care home workers. Although the concept was a restriction on individual choice, there were parallel requirements in respect of other viruses and diseases, and the decision was necessary to protect the most vulnerable in society. I was in no doubt that it was the right thing to do. On 17 March, at a Ministerial meeting of COVID-O, it was agreed that the Government should proceed to take steps to make vaccination a condition of deployment, while also working on non-legislative solutions in the interim, including the assessment and mitigation of any particular impacts on disproportionately impacted groups: (MH6/168 - INQ000092064; MH6/169 - INQ000091817; MH6/170 - INQ000234310).

191. In response to a submission on this issue, received on 25 March 2021 (MH6/171 - INQ000234311), I agreed that the Department should run a consultation on mandatory vaccinations for care home workers, which opened on 14 April. Following receipt and consideration of the consultation responses, I announced on 16 June 2021 that the Covid-19 vaccination would become mandatory for care workers, with a grace period of four months to enable workers to obtain a vaccination if they had not already done so.

192. Around the same time, and considering that the same public health concerns were applicable to healthcare staff who worked with vulnerable patients as well as visiting care home patients, the Department announced that it would run a second, similar consultation in relation to the mandatory vaccination of all other healthcare staff. This was dropped, without good reason. However, this science-based policy has been a very significant success. The concerns raised, especially about staff leaving these caring professions, did not materialise. One important lesson is that mandatory vaccinations for Covid-19 and flu should be extended to all health and social care staff to save lives.

193. I drove the initial move to require health and care staff to be vaccinated. It was and remains my strong view that vaccination should be a condition of deployment; if you are working with vulnerable people (as health and care workers do) then it should be self-evident that you should do everything you can to protect them from harm. This includes clinically valid vaccination. The statistical evidence supports the position that a greater degree of protection is provided to those in receipt of care where their caregivers are themselves protected, as should be self-evident.

194. Insisting on vaccination as a condition of deployment did not, as far as I am aware, drive any great number of health or care professionals to leave their posts and undoubtedly had both a positive impact on vaccine uptake, and saved lives.

195. As to why the consultation in relation to vaccination as a condition of deployment was dropped without good reason; I am not aware of any good reasons. I know some trade unions are unthinkingly against vaccination as a condition of deployment – they will have to answer for their rejection of care, science and objective fact.

Travel Resumption

196. In late March, we agreed that the UK should adopt a 'tiered' system to international travel, moving from red (high risk) and amber (lower risk) countries to a more nuanced range of red, amber plus, amber, and green countries, reflecting the risk posed by the relevant countries and therefore informing international travel. As was the case previously, those returning from red list countries would be required to enter a Managed Quarantine Service on their return. An amber plus designation would serve as a warning that a county may be escalated from amber to red, thereby requiring MQS on their return. (MH6/172 - INQ000091831; MH6/173 - INQ000091832; MH6/174 - INQ000091833; MH6/175 - INQ000091834; MH6/176 - INQ000091835; MH6/177 - INQ000091836; MH6/178 - INQ000091837; MH6/179 - INQ000091838;

MH6/180 - INQ000091839; MH6/181 - INQ000091841; MH6/182 - INQ000091849; MH6/183 - INQ000091851; MH6/184 - INQ000092425; MH6/185 - INQ000092426; MH6/186 - INQ000091853). International travel was resumed on 17 May as part of Step 3 of the roadmap.

197. The NHS app was strengthened so those wishing to show their vaccination status abroad or to travel could do so. This was a very significant success, and the data integration internationally was unprecedented, which meant the NHS app could be used in many countries that had vaccine passports. Around three quarters of the adult population has now signed up to the NHS app (MH6/187 - INQ000480972).

198. In the UK we considered vaccine or testing passports repeatedly. However, other than for international travel they were never introduced. On balance I think this was the right decision. For vaccine passports to work effectively, the clinical advice was that they needed to be applied in a very wide variety of settings, including pubs, restaurants, places of work as well as large events. They are therefore likely to be divisive as a social distancing tool. While some object in principle, I supported this practical reservation. Nevertheless, an international study of their effectiveness would be valuable, as in considering future social distancing measures to suppress a future virus, we should not only consider the tools we did use, but also the ones we did not, so as to be able to suppress a future virus at the least cost in future, according to the doctrine I have set out.

199. I have tried to set out in this statement, and to the best of my ability, the facts about what happened, and my recollections about what went well and what went badly in respect of the vaccine programme. From my role in ensuring that the development of the vaccines and the rollout was a success, I learned that there is a need to constantly set stretching, but achievable, targets, then to keep on top of them to ensure that each person is doing their bit to meet them. I am pleased to say that taking this approach meant that we hit all of them.

Prohylactics

200. I am asked by the Inquiry about prophylactics: I supported developing prohylactics for the benefit of those people who could not have a vaccine, but was not involved in clinical judgements around their potential effectiveness compared to other treatments.

Vaccine Damage Payment Scheme

201. At the start of the pandemic I supported using the existing Vaccine Damage Payment Scheme ("VDPS"). While in the short time available it was not considered necessary to amend it during the pandemic, I can see force in the argument that it is a blunt instrument and that there is a reasonable case for compensation that is more proportionate to the damage caused to be provided by the Scheme, whilst still being capped.

LESSONS LEARNED

202. In Module 2 I set out a number of lessons learned including:

a. the need to continuously optimise the regulatory process;
b. the requirement to build a manufacturing capacity and maintain a system to distribute vaccines;
c. The importance of conducting more clinical trials in parallel;
d. The vital requirement for a system for challenge studies, with pre-agreed protocols for immediate deployment to accelerate vaccine trials.

203. In addition I would suggest that the Inquiry can draw the following from the success of the vaccine programme:

a. Extraordinary things can be done when you have a powerful national mission with strong leadership, funding, and clear accountability;
b. Rigorous modern use of data is vital for success. All four stages – science; commercials; regulation; and deployment – started with building the right the data architecture;
c. Support the independent regulators and advisors to make the best possible, science-based decisions, and protect them as much as possible from populist pressure and conspiracies;
d. It is critical to back all horses. Many of the vaccines we bought did not work. We were very lucky, for example, that the first two approved – Pfizer and Oxford/AstraZeneca – could be manufactured at scale quickly. We did not know this, even when the first jabs were delivered. Many trials failed, and many successful vaccines could not be scaled. We did not assume success – we backed every horse that could run;
e. Set clear, stretching, measurable goals. From the very first decision in January 2020 to go for a vaccine within a year, goals have a galvanising effect on the system and provide clarity of purpose; and
f. Bring in the best, and delegate to people to deliver their best.

204. There are many many other lessons, but these are the big ones.

205. All of these lessons lead towards the rationale for the 100 days in the '100-days project'. It is my view that 100 days is currently the shortest credible time in which a vaccine might be produced and it therefore represents the most stretching realistic goal. As the technology and processes of vaccine development are improved, it may well be that the goal can be reduced yet further. A good goal must be just about achievable: so once we can develop a vaccine in 100 days, that is the time to stretch the system yet more.

Statement of Truth

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

Signed: Personal Data

Dated: 2 October 2024