Friday, 17 January 2025

(10.00 am)

Statement by THE CHAIR

LADY HALLETT: Good morning. Before we -- forgive me, Lord Sharma, I just have a few words to say.

Before we resume our evidence for Module 4, I wanted briefly to mention Module 1. On 18 July 2024, I published my first report for Module 1 which examined the United Kingdom's resilience and preparedness for the Covid-19 pandemic.

In the report, I set out a series of findings and recommendations which were put to the four governments of the United Kingdom: the United Kingdom Government itself, and the three devolved administrations.

I set a deadline of six months for them to respond from the date of the report's application. Yesterday, all four governments met my deadline and their responses have been published on the Inquiry's website. I will be carefully considering all of their responses in the coming days.

Thank you.

MR KEITH: Thank you, my Lady.

Could the first witness today, Lord Sharma, be sworn, please.

LORD ALOK SHARMA (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

MR KEITH: Could you commence your evidence, please, by giving us your full name.

A. Yes, my name is Alok Kumar Sharma.

Q. Thank you very much, Lord Sharma, for attending today and for assisting the Inquiry, in part through the provision of your witness statement dated 15 November 2024, INQ000474590, the truth of which you have declared to through your signature.

Lord Sharma, you were the Secretary of State for Business, Energy and Industrial Strategy in the department, the acronym for which is B-E-I-S, but I think is commonly pronounced BEIS, or was pronounced BEIS, between 13 February 2020 and 8 January 2021, a month or so after the commencement of the vaccine rollout programme.

Lord Sharma, it may help if I simply observe that the focus of this module is not to recreate forensically what happened throughout those terrible days within your department, or to recreate the processes and the systems which were deployed to deal with the vaccination and therapeutic programmes. We're focusing on learning lessons from what went well, so they can be embedded in the future, and also trying to identify what didn't go

quite so well.

So we're going to focus on a handful of discrete points which came within your reach in that department.

Was BEIS, as it was then known, I think it's now DSIT, the Department for Science, Innovation and Technology, responsible in part for industrial strategy, and that included science, research, innovation and the like?

A. Yes, it did.

Q. And so was your department the department that was most closely involved in the issue of research funding?

A. Yes, absolutely. So BEIS basically was the department under which UKRI sat, along with a number of other bodies. So yes, indeed, we were.

Q. I'm going to assist everybody by saying, by just observing that UKRI, is that UK Research and Innovation?

A. Yes, indeed.

Q. We must try to steer away as much as we can from acronyms.

The UK Research and Innovation, was that a non-departmental public body but which happened to be sponsored by your department?

A. Yes, indeed.

Q. I think it was launched in April 2018, so it had been in place for a while prior to the pandemic. Was it then,

it may still be, the UK's largest public research funder, so not just health and social care, but across a vast range of research and development?

A. Yes, I believe so, and clearly the budgets that went for UKRI, UK Research and Innovation, came through the Department for Business.

Q. And the budget was to be measured, was measured, in the billions?

A. Yes.

Q. There are many references in the paperwork to the valuable work done by the seven disciplinary research councils in the United Kingdom, in particular the Medical Research Council -- there's another research council called Research England -- do they fall within that framework coordinated by the UK Research and Innovation body?

A. I mean, I don't know the current sort of set-up but certainly funding flowed from UKRI directly to some of the councils.

Q. There was another funding body, the National Institute for Health Research, now called the National Institute for Health and Care Research. It was traditionally headed by the chief scientific adviser, I think, in the DHSC, who was of course, then, Professor Sir Chris Whitty.

A. Mm.
Q. Not, I should say, the Government Chief Scientific Adviser, who was, of course, famously, Sir Patrick Vallance, as he then was. And I think the chief scientific adviser in the DHSC now is Professor Lucy Chappell.
But that's another funding body which focuses, does it not, on health and social care specifically. Was the funding that it provided, however, something that your department had a close eye on as well?
A. It isn't something that I was particularly focused on, but obviously we had the Office for Life Sciences at the time, which was a -- joint oversight from both the Department for Health and the Department for Business, so I suspect within the department there would have been awareness of what was being done.
Q. Is that body one of the largest government funders of medical public health and care research in Europe?
A. Yes, I believe so.
Q. Importantly was that body an integral part of the research and funding that took place in the run-up to the pandemic for the research that was going on at Oxford University under Dame Sarah Gilbert's team which of course led to the as centre vector --
A. Yes.

Q. -- vaccine, and also, research that was going on at Imperial College under Robin Shattock?
A. Yes, indeed, and in fact there was an initial, I think, £30 million fund, Covid fund, which was made available, which ultimately stood under the Department of Health in terms of being able to deploy to support research into Covid treatments.
Q. And it's important also to recognise the work done by what's known as the UK Vaccine Network. I think that is particularly concerned with the development of vaccines and vaccine technology for infectious disease in low and middle income countries, but it did also provide significant funding for research and development projects pre and during the pandemic?
A. I'm not aware of precisely what level of funding that provided.
Q. All right. Well, you can take it from me it also funded Oxford University's adenoviral vaccine research and development funding -- vaccine work in 2019.
Could you also very briefly please tell us about GO-Science. What is GO-Science and was that another area for which your department had at least indirect responsibility?
A. Yes, it did have responsibility for that and GO-Science was obviously the Office for Science, which was involved

in scientific research and support.
Q. And did your department also have overview of the Office for Life Sciences, which is a government body which promotes innovation, research and technology for work in the health and social care sectors?
A. Jointly within the Department of Health.
Q. Thank you very much.
Now, it is very well known, of course, that within your department there was instituted the Vaccine Taskforce, the VTF. The position appears to have been this, that in late March 2020 the chief executive of the Bioindustry Association asked Sir Patrick Vallance whether a taskforce could be instituted connected to central government and out of that came Sir Patrick Vallance's idea, and he must be permitted to take credit for this, of course, the idea of a governmental vaccine taskforce, and was that something that you were formally approached about in March 2020 and which you approved on the same day?
A. Yes, I was approached on 26 March by Sir Patrick and also Sir Mark Walport and the same day I wrote to them setting out my support and my department's support for the VTF.
Q. So in very significant terms your department was the father and mother of the Vaccine Taskforce, and was its

creation driven particularly, in fact, by a member of your department, Alexandra or Alex Jones who was the director of science, research and innovation?
A. Yes, I mean, she played a key role.
Q. Thank you.
Can we just, please, have up INQ000478917.
We can see your letter to Sir Patrick Vallance, who was, as I've said, the Government Chief Scientific Adviser, and Sir Mark Walport, former Government Chief Scientific Adviser in fact, but who also happened to be the chief executive --
A. Yes.
Q. -- of UKRI, the BEIS-sponsored or managed funding entity.
And we can see there that you refer in the fourth paragraph to Sir Patrick Vallance having outlined his plans to set up a Vaccine Taskforce and a Therapeutics Taskforce to look further into what we can do. You welcome it. You direct your officials accordingly, and you agree.
A. Mm.
Q. Perhaps the most prominent feature of the Vaccine Taskforce was its external chair.
A. Yes.
Q. Why was the Therapeutics Taskforce, which was also set

up around about the same time, not chaired in the same way by an external head? Can you recall?
A. I can't, for the simple reason that obviously the decision was made fairly quickly, formally by the Prime Minister, I think, on 13 May, that therapeutics should sit outside the remit of the Vaccine Taskforce, but I can certainly tell you that I believe the reason the Vaccine Taskforce worked as effectively as it did, was because we did have Kate Bingham, now Dame Kate, I think she showed, you know, the right skills in terms of scientific, but also in terms of bringing her private sector knowledge into play.

Secondly, I do also think it's quite important the fact that she reported directly to the Prime Minister. I think that link to the centre was very important and, you know, secondly, we had a set of people that she was being supported by, many of them from within the Civil Service itself, who had private sector experience, and that public/private partnership I think was vitally important.

Finally, I think the VTF worked because we were able to make rapid decisions particularly on funding.
Q. Just focusing for a few minutes more on some other aspects of the VTF. It's important to emphasise, isn't it, that whilst it had an external chair, its external

advisory group and what in fact became the heart of the Vaccine Taskforce was a combination of civil servants and external professionals?
A. Yes, I --
Q. So it wasn't just external, there was a very significant Civil Service element in particular, I think its Director General Nick Elliott, Madelaine McTernan, also were civil servants?
A. Yes, I think that's absolutely right, and I think it's important to emphasise that whilst we had Kate Bingham who came in and did an excellent job and we had external support, a lot of the people involved were civil servants brought in from within the different departments and I think they played a really key role in making it a success.
Q. And the VTF was also, as with all government departments ministerially accountable to Parliament through your department, of course, because it was a BEIS body?
A. Yeah.
Q. And was that one of the significant differences from the Therapeutics Taskforce, as it became subsequently, because that wasn't exclusively a BEIS body, was it?
A. It wasn't, and forgive me, Mr Keith, I can't really comment on the Therapeutics Taskforce because I wasn't involved. I know the decisions that were made around

how it was run, but certainly I think the fact that the VTF had a very clear mission, very focused, led by someone who was incredibly "can do" and the ability to make fast decisions, particularly when it came to funding, I think created the success for the VTF.
Q. And so I'm driven to ask, perhaps a fairly obvious question, Lord Sharma, which is this: if one recognises that the most prominent features of the VTF were its ability to work at faster pace, its external expertise, the right combination of Civil Service experience and external professionalism, and its can-do approach, firstly, why aren't other bodies promulgated within the government machinery in the same way, and why wasn't some of the other comparable bodies like the therapeutics Vaccine Taskforce set up in the same way?
A. Yeah, well, I think that is actually a key lesson that I think we should be learning, is, you know, what were the ingredients that made the VTF a success, and if, you know, God forbid, we should face another similar emergency, whether other similar bodies should be constituted in the same way.
Q. Could we just look then briefly at just a couple of the most important documents from around this time INQ000533814 -- thank you -- dated 2 April. It's a formal BEIS submission to you, the Secretary of State,

as well as your fellow ministers. The summary states plainly that you'd asked Sir Patrick Vallance to establish a cross-government Vaccine Taskforce. If we could just look at page 2, paragraph 6, we can see there the strands of work which you had directed be carried out: supporting discovery of potential vaccines, preparing the UK to offer itself as an expert clinical testing site, reviewing the regulations ... developing funding and an operational plan, and build on the UK's research and development expertise.

I want to ask you about the second bullet point, the expert clinical testing site.

Why, when a government is reaching out into the industrial sphere and seeking to bring manufacturers on board to research, develop and manufacture vaccines, is it so vital to be able to offer those manufacturers, as well as the British public, proper, well-funded, developed clinical testing sites? Why is the need for a proper platform to test vaccines so critical to the willingness of manufacturers to engage?
A. Well, clearly, for any pharmaceutical treatment it needs to go through a testing process through a number of phases and that does involve, you know, having those clinical trials and therefore making sure that you are organised for that clinical testing ahead of vaccine

compounds being available was vitally important. That, plus, obviously, the issue on manufacturing which was, again, something that we spent quite a lot of time thinking about and actually putting money behind.

Q. And we'll come back to that later.

Why can't manufacturers do their own testing in their own sites, perhaps abroad? Why is it so important that the United Kingdom as a country can assist with that process?

A. Well, I think there was clinical testing with a number of vaccines that were used abroad --

Q. There was, yes.

A. -- as well, so I think it's not an exclusive thing for the UK. But certainly from my point of view, and I don't claim to be an expert on sort of clinical testing, but, from my point of view, I think the pace at which you can get things done, the ability to have oversight over that, I suspect is probably easier if you're doing that domestically, and for the government to be able to help direct that, and particularly build a population of people who are willing to volunteer to be, you know, part of the clinical testing. That's something we did, and I think people did respond to that in the population.

Q. And there was in fact a Vaccine Registry?

A. Indeed.

Q. And people were allowed to sign up for it and very large numbers of people did --

A. Yes. I mean --

Q. -- to their credit.

A. -- hundreds of thousands signed up.

Q. Of course, the making available of vaccines was the primary objective for the Vaccine Taskforce, but there were two other objectives, were there not: firstly, to provide vaccines globally to provide global assistance; and, also, to build up resilience within the United Kingdom for the future.

On that second point, global assistance, could we have INQ000533814, page 2.

I think I've -- I think we've gone to the same document. I'm sorry, that's my mistake.

Can we have INQ000330577. Thank you very much.

This contains a reference to a meeting with the Prime Minister.

A. Yes.

Q. I want you, please, to emphasise that the government's direction, very strongly and personally driven by the Prime Minister, was not just about providing vaccines for the United Kingdom and for its population; he was extremely concerned that the whole world be immunised as

quickly as possible, hence the second objective of the Vaccine Taskforce, and we can see there in the last paragraph:

"He has a profound and deep rooted aim that the world be immunised as quickly as possible."

So it wasn't a nationalistic -- an individual country approach wasn't being taken here, there was a much wider agenda.

A. No, absolutely not. And I think it was very important that the UK participated in COVAX, the COVAX facility, it participated in some of the other initiatives through the World Health Organisation, and others. And, you know, if we think about the negotiation on the AstraZeneca vaccine, for instance, I mean, you know, huge credit to AstraZeneca for providing that effectively at cost. And so absolutely, from our point of view, yes, we wanted to ensure that we were making vaccines to support the population of the United Kingdom but also to make sure that we were able to support people in other countries.

Q. The Vaccine Taskforce, in a formal recommendation in December 2020, recommended in future the creation of a national vaccines agency, and Dame Kate in her own book has promoted that recommendation, as indeed have a number of other people, a vaccine agency that would be

largely what the Vaccine Taskforce did so successfully but provide an end-to-end governance, that's to say being responsible for supply chain readiness, research and development, transfer and stockpiling, clinical trials, all the way up to the point of delivery, which obviously is for each of the devolved administrations and England. Would you support that proposition, that recommendation?

A. Well, I certainly think it's worth giving quite a lot of thought and consideration. I guess it depends precisely what the remit of such an organisation is, and how it docks into government.

I mean, I think one of the benefits of having the VTF is, yes, it had oversight but -- we brought in external people but it very clearly docked into government, and particularly then it came to funding decisions it was important that it was close to the centre.

And also I think it was understood that, you know, the VTF would -- at some point, you know, its life would come to an end, it would morph into something else. So I guess the question for me is that if you have a National Vaccines Agency, what I don't think you would want is for it to, you know, eventually become business as usual. You know, what --

Q. It needs to be different?
A. It needs to be different. And I think what the VTF brought was that sense of urgency and national wish which everyone was driving towards. So I think you'd give it some thought.

I mean, one of the things that I have set out in my statement, Mr Keith, is perhaps a precursor to this, is to have an external advisory body which combines external experts, actually perhaps some of the folks who worked on the VTF, plus ministers and civil servants, meeting on a regular basis every -- throughout the year, and actually scanning the horizon for what are the risks from a health point of view and then effectively doing an audit and looking at whether the UK actually has the capability to be able to deal with those external threats. Certainly from my point of view I think that's one of the things that I would like to see.

LADY HALLETT: Lord Sharma, I'm sorry to interrupt, yesterday, I think it was Mr Hancock who questioned the need for a separate agency because he said it's the -- really it would be the task of the UKHSA.

Had you thought about whether a separate agency or a separate advisory body would be necessary in addition to the UKHSA -- I do hate acronyms, but anyway -- that's why Mr Keith told you not to use them. Have you thought

about whether the UKHSA could provide this advisory body and perform the task that ...
A. Potentially, but I think, from my perspective, the issue is here is how do you ensure that we have readiness the next time something like this happens. And, you know, this is why I talk about the fact of having an external advisory body which then effectively provides advice into some of the established organisations and provides, perhaps, oversight on making sure that they are working.

I think it's definitely worth thinking about whether you create a national vaccines agency, but for me the issue is if that just becomes a business-as-usual type organisation, the pace that I think the VTF brought perhaps wouldn't necessarily be there.

MR KEITH: If I may, it may be that by asking you whether you were to promote -- you do promote a national vaccines agency, I premised the question on perhaps a false basis, which is that such a new body would be an entirely governmental body, a quango, a -- well, a departmental body.

What you're saying in essence, Lord Sharma, appears to be that the essential feature of the VTF must be maintained, which is that it has that external element in it, and the external professionalism 'can-do' pace of response, whilst remaining ministerially accountable

still to Parliament?
A. Yes, but I also think that what's important is that whoever leads that body, that advisory group, should be able to report directly in to the Prime Minister of the day. I think that's one of the things we saw from the VTF is that that direct report from Kate Bingham in to the Prime Minister was actually very important.
Q. In her book, Dame Kate makes a number of wider recommendations relating to the working of government, and, if I may, I hope you'll forgive me, could I just put some of the essential elements about what you suggest about the benefits and demerits of working with Whitehall and see whether you've got any observations on them.

She says that she encountered too great a focus in Whitehall on procedures and process and not outcomes. There was a culture of underperformance, rapid rotation in staff, a failure to give prominence to STEM graduates, that's to say persons expert in maths and the sciences, and the whole system of recruitment and Civil Service staffing requires a very good look at it.
A. Mm.
Q. In the context, I should say, of something as specific and perhaps as scientific as vaccines and therapeutics?
A. Yeah, yeah. Well, I think the first thing I'd say is

that, you know, many of those people who worked on the VTF were existing civil servants.
Q. And I've put that to you, yes.
A. And some of them brought external skills, as well, in terms of negotiations, in terms of project management, and I think that was important. I think, you know, some of the points she raises around more STEM graduates in the Civil Service, I think she makes the point that there should be more ministers who have STEM backgrounds, I think that's important. I think she talks about outcomes rather than, sort of, process. I think all of that is there, but, you know, and, you know, we could have a long discussion about, you know, the potential ways of improving the Civil Service, but specifically when it came to the VTF, yes of course, you know, there were occasions where you would have wanted things to perhaps move faster, and certainly she's very clear in her book that she did, but ultimately, I did not feel that the VTF and the decisions we were making, you know, ultimately, particularly when it came to funding, were in some way impeded by the Civil Service as it is.

I think she talks about the fact that one of the reasons the VTF worked is because there was a venture capital mindset and, actually, I think she's absolutely

right about that. And yes, perhaps we should have more of a venture capital mindset in government, but clearly what you don't want is everyone in government to have a venture capital mindset because, you know, you're talking about public money, you're talking about accountability and ultimately I don't think that, you know, despite some of those frustrations, we -- there were delays in terms of getting things done.

Q. It's very clear that one of the primary drivers for the VTF's success was that their approach to procurement was a risk.

A. Yes.

Q. By which I mean they were prepared to tie the government into paying in advance for manufacturing capacity, in advance of the clinical trials. And that obviously couldn't have been done without the -- in fact, the express assent of yourself, your ministers, your fellow ministers, and the Prime Minister.

And it's obvious that not every, as you say, not every government department can purchase a risk and it's an extremely dangerous process. But it worked for the VTF. Do you know whether or not that same mindset was equally applicable to the Therapeutics Taskforce in relation to which some have said: well, it didn't have quite such a "can do" approach. The same principal

position wasn't taken at the start in relation to the purchase and manufacture of therapeutics.

A. Yes.

Q. Would you agree with that?

A. Forgive me, I genuinely cannot answer that question because, I mean, I had some involvement with therapeutics through phase II trials on ACCORD --

Q. Yes.

A. -- but in terms of the running and the workings of the Therapeutics Taskforce, that wasn't something that I had any oversight or, frankly, involvement in.

But if I may just add --

Q. Please.

A. -- Mr Keith.

This issue of doing things at risk, I do think that was very important and again, I think that was one of the successes of both the VTF, but also actually the recognition within government and the Treasury that things needed to be done at risk. I mean, at the end of the day we had a funding envelope of 5.23 billion. I know there were frustrations in terms of, you know, it taking a few weeks to sort of get established, but again, I think relative to business as usual, agreeing a 5.23 billion funding envelope, things actually moved pretty fast.

Q. It was a remarkable structure, was it not?

A. Yes, it was.

Q. You were part of the ministerial panel, the draft terms of reference, we can have up, please, on the page, on the screen, INQ000330584. Page 1 at paragraph 2.

The panel of which you were part was obliged to provide commercial and financial approvals for any vaccine procurement contracts over 150 million. So anything over that amount had to be agreed to by yourself and your colleagues. Anything under had to be agreed to, of course, by the civil servants in BEIS, and the Vaccine Taskforce, and of course you're all responsible to Parliament for this public expenditure.

I think your panel met eight times between August and December 2020, so at a very rapid pace. Is that why you say it wasn't business as usual?

A. Yes, it met eight times, I think the first time was 27 August and the last on New Year's Eve.

Q. The 31st --

A. 31 December 2020. And bringing together, you know, senior ministers around the table, I think was really important in terms of that rapid decision making. And I think that -- you know, in terms of the funding decisions up until that point, you know, there were some, sort of, big numbers, but not at the scale that

needed to be made decisions on when it came to procurement of the actual vaccines, and I think it was understood by everyone that actually we needed to have a slightly different system to make this work. So actually bringing together the Treasury, the Cabinet Office, obviously the Department of Health, and the Department for Business, I chaired that Ministerial Investment Panel and I think, you know, that again is one of the innovations we should be thinking about for the future is that, you know, if we face a similar type of emergency, whether right from the start in terms of making funding decisions, we should have all the key departments, but particularly the Treasury and the Cabinet Office being part of that decision-making process.

Q. And that feature to which you refer of having the Treasury in that body means, of course, that they get hanged with the joint petard, that you have them on board agreeing to this as part of the ministerial panel review process as opposed to forcing BEIS, and the Vaccine Taskforce, to have to go to the Treasury on a case-by-case basis separately --

A. Yes.

Q. -- and ask for permission to spend vast sums of money one after the other?

A. Yes, and, I mean, initially obviously we did it on a case-by-case basis and I don't recall that there were any particular delays in terms of getting agreement on that funding but as I said, I think it was recognised that when it came to these very, very large funding decisions we needed to find a more efficient way of doing this.

Q. Another aspect of this vast public expenditure, which is of public interest, is the issue of indemnities.

A. Yes.

Q. Because, of course, all the manufacturers, understandably, sought indemnities of one sort or another. They were being forced at pace to produce vaccines for the benefit and welfare of every government and every person in the world.

A. **(Witness nodded)**.

Q. They all initially, I think, sought full statutory immunity, that is to say a complete bar to being sued, which by and large is the position in the US, where there's an Act, the Public Readiness and Emergency Preparedness Act, which provides a very wide cut-out or exemption from liability. UK ministers successfully pushed that away; is that right?

A. We did, and I think it was actually recommendations by the officials and we very much accepted that, that at

the end of the day from a taxpayer perspective, it made much more sense for, you know, individual companies to come to us with their asks rather than us giving statutory immunity. And, anyway, I think giving statutory immunity would have required effectively an Act of Parliament and so that was resisted.

What it also allowed us, the negotiating team to do, is -- of course, there were, sort of, common indemnities given for the vaccine manufacturers but there was an ability, as a result of going down the indemnity route, to have some variations as well, and that did happen. I think that was very positive.

Q. And so that we're absolutely clear about this, the indemnities that were agreed on a case-by-case basis with each individual manufacturer by the government, in no way prevented anybody from bringing a claim against a particular manufacturer, not least under the Consumer Protection Act. The indemnity didn't and doesn't prevent access to the court and in the event of a claim being brought, it is the manufacturer who is the defendant?

A. Yes, precisely that, Mr Keith.

Q. So the indemnity took effect, in fact, simply by way of an after-the-event --

A. Yes.

Q. -- willingness on the part of the government to pay for the manufacturer any award or damages made against it as well as any legal costs --

A. Yes.

Q. -- in certain circumstances?

A. Yes, in certain circumstances. I mean, there were a number of carve-outs --

Q. We won't go there but it wasn't a blanket "We're going to pay the cheque" agreement, it was "We'll pay any award of costs, any award of damages, but only if the courts order it", as well as legal costs, and only in certain circumstances, or at least not in all circumstances?

A. Yes, that is absolutely right. And I would just add one other point on this.

Q. Please.

A. Obviously there was work done in terms of looking at the contingent liability for government as a result of giving these indemnities. There was also work done on what was the net benefit of having vaccines being deployed successfully, and clearly the net benefit calculations showed that it was many multiples higher than the potential contingent liabilities.

Q. But by that do you mean this: that because you're dealing with public funds, the government was obligated

to weigh up the potential contingent cost of picking up the tab for a manufacturer who loses in the court and weigh it against the overall financial advantage to the United Kingdom by having a vaccine, or vaccines, and a delivery programme?

A. Yes, and I think this issue first emerged, and I set this out in my statement, I think, when we were looking at reservations for Pfizer BioNTech, and I was presented with a calculation in terms of the contingent liability for the government, and I asked for that to be revised and for more work to be done so that we could be certain in terms of exactly what we were looking at, because that initial calculation was actually a very large range.

Q. Well, it must have been an extremely difficult task to try to quantify the financial worth to the United Kingdom of having a successful vaccination programme. I mean, that's not a straightforward task.

A. No, it's not a straightforward task but I think, you know, as the contingent liabilities were revised as a result of more information from the Department of Health, knowing that certain groups were initially not going to be getting the vaccine, I think that helped in terms of the contingent liabilities piece, and yes, I think the range in terms of the net benefit to the UK

was actually a pretty large range but nevertheless, even at the lowest level, it showed that there was a net benefit of very many multiples compared to, kind of, the maximum exposure when it came to indemnities of the government.

Q. The net benefit to the United Kingdom financially and societally vastly outweighed any possible contingent liability that might ever be owed --

A. Yes, absolutely.

Q. -- to a manufacturer?

A. Absolutely.

Q. Right. And those indemnities were agreed at the highest level. They went to the Prime Minister, they were agreed on a case-by-case basis and no doubt they were the product of a great deal of thought. Do you consider that the UK Government was over-generous in its general approach to indemnities?

A. No, I think we were very pragmatic and I think the negotiating team deserves a lot of credit for this because they did push back very hard on this strategy immunity which, frankly, you know, a lot of the manufacturers, particularly as you said, Mr Keith, they were used to that in the US with the prep Act, they were very keen to push, and I think the team did a great job in resisting that.

Q. There was a paper produced for you in August 2020, 27 August, INQ000478999. If we could just have page 1, please, firstly.

You were being invited to reconfirm your acceptance of the general approach to government indemnities, and in fact to note where things had reached in relation to the draft AstraZeneca supply agreement. And we can see there, in the first paragraph, the reference to statutory immunity, or government-backed indemnity which, as you say, the UK Government negotiated its way away from.

We can see in paragraph 2 the reference to the US Act which gives very wide-ranging immunity.

If we could go over the page to page 2, we can see there under "Likely costs" some of the thinking relating to the contingent liability figure to which you've already spoken.

A. Mm-hm.

Q. We can see there was obviously a range of benefits or a range of worst-case scenarios.

Can we then go over the page to page 3, where I think there's a reference to -- yes, paragraph 12, "Ministers were invited to note that the DHSC is reviewing the UK Vaccine Damage Payments Act", which is, as you know very well, the statute that provides for the

Vaccine Damage Payment Scheme, a non-compensatory flat-rate scheme --

A. Mm.

Q. -- for 60% disablement or more.

There's a reference there to officials considering options to expand the list of vaccines and to review the eligibility criteria.

A. Yeah.

Q. Do you happen to know what happened to that review, and also to the possibility that appears in the line below, to a separate compensation, and that's an important word, compensation scheme, not just a payment scheme, for vaccines?

A. I think as it sets out, this was ongoing work between the Department of Health and the Treasury. I mean, as I understand it, and please forgive me, I mean, obviously, I left at the beginning of January from my post.

Q. You did.

A. But as I understand it, obviously, Covid-19 as a condition was inserted into the Vaccine Damage Payments Act. I think the amount of compensation stayed the same, but certainly I think one of the things that, you know, reflecting on this and particularly, I think, seeing some of the testimony on the impact film for this module, I certainly think there is a case for us to look

again at both eligibility criteria but also perhaps to look at the quantum of money that would be made available through this mechanism.

Q. Thank you, that's --

A. That's obviously for the future. Just to be clear.

Q. And of course it is something that ministers would have to agree to and it also, of course, has a statutory and Parliamentary foundation.

On an entirely separate subject could I please ask you about the Vaccine Manufacturing and Innovation Centre, VMIC.

A. Mm.

Q. You've referred to the importance of having a proper, developed manufacturing -- onshore manufacturing capacity in the United Kingdom, so that in the event of a future pandemic there is a ready, available, ready-to-go system for the manufacture of vaccines, of course therapeutics, all the ancillary materials and substances, the -- is it fill and finish, finish and fill process?

A. **(Witness nodded)**

Q. As well as, particularly, antibodies.

A. Mm.

Q. Your department had funded, to a very considerable extent, VMIC, along with the UKRI and the DHSC.

Could we have, please, INQ000506819. Thank you very much.

We can see there a reference to VMIC, in paragraph 15 a reference to the original funding.

A. Yes.

Q. 69 million.

A. Mm-hm.

Q. And then, further down -- thank you very much. And then, in paragraph 16 and following, references to the expectation that there would be extra capacity, that the centre would be built, it would be opened by June 2021. And then, in paragraph 19, further costings and further funding which might be required.

You asked for further detail of what was likely to happen and what was likely to be sought by way of funding and you received a further submission, and in December you were asked to approve in principle another 50 million or so.

A. -- 47, yeah.

Q. 47.6 million. Was that something that you approved or was that decision on funding taken by another of your ministers?

A. So I think at that point I delegated that to Nadhim Zahawi, who was, you know, ultimately the Vaccines Minister, in terms of deployment. But clearly,

I supported it. I thought it was very important that we build up manufacturing capacity, not just to deal with vaccine manufacturing during the pandemic but obviously permanently for the future as well.

And, Mr Keith, you showed me that email from Emily Beynon earlier, from Number 10, was it the Prime Minister's private secretary, and that very clearly referred to the role -- some of the roles of the VTF was to build up manufacturing and R&D.

Q. It's a matter of public record that the VMIC facility was sold, in fact it was a separate entity. Its board --

A. Yes.

Q. -- decided that, due, in fact, in the main, to market conditions, it simply wasn't a going entity any more. And the best way to proceed was to sell itself to an overseas, international, commercial company, to try to recapitalise the structure.

It had obviously had, by then, a great deal of public money. Is it your position that it is vital that that manufacturing capacity is maintained for the future, that the centres are ready to go, and that they are available, at literally a moment's notice, to turn their manufacturing capacity to the production and manufacture of vaccines and therapeutics?

A. Yes, absolutely right, I agree with that entirely.

And if I may reflect on VMIC, it was obviously manufacturing but also an innovation centre. And, you know, by the end of this sort of process the government had invested £200 million in this facility. Clearly in the autumn of 2021 the directors decided that, you know, it should be sold and it was sold early on in 2022. But of course, as I understand, it was then effectively mothballed. And, you know, obviously I was not part of the decision in selling it. If I had still been in post, I would certainly have asked a lot of searching questions as to whether or not it was right to sell this.

But just reflecting on this, I think the question for me is that, you know, the advantage of VMIC was that there was government involvement, government investment, Innovate UK had oversight. So we could, you know, to use your words, "at a moment's notice" turn to that facility in terms of manufacturing. And the question for me is, if not VMIC, then what now, if we face a similar emergency tomorrow?

Q. So we understand the position, Lord Sharma, there are obviously a number of different angles and aspects to the manufacture and production of vaccines and therapeutics, but at the time of the pandemic there was

a biomedical facility at Oxford.

A. Mm-hm.

Q. There was a production line run by a company called Wockhardt in Wrexham which provided vaccines. There was a vaccines site in Braintree. All this had to be stood up --

A. Yes.

Q. -- to use a terrible expression --

A. Yes.

Q. -- from scratch --

A. Yes.

Q. -- funded at vast expense and very quickly indeed in order to be able to provide the manufacturing capacity which was so sorely needed?

A. Yes. And I think in terms of at Oxford Biomedica, I mean certainly one of the questions I asked when we got this submission on VMIC -- which showed that, you know, it could be up and running a year earlier than envisaged, so, you know, middle of 2021 -- I did ask what could be done more immediately to get manufacturing going. And I think the solution, which was I think already being worked on, was to move VMIC equipment and staff into Oxford Biomedica's facilities, so basically in those cleanrooms, and they were used for manufacturing, I think AstraZeneca, vaccines during that

period.

And just reflecting on one more point, I think you made this issue about not just vaccines but also antibodies, you know, during this period, I also approved funding to acquire a manufacturing capacity abroad for antibody therapies, and I certainly reflected at the time that actually, you know, why is it that we didn't have this capacity in the UK? And I think that should be another learning from this, is that not just the manufacturing of vaccines but also, as you said, fill and finish, but, in addition, antibodies. If we needed this tomorrow, could we actually do this in our own country?

Q. That was, I think, a submission dated 24 June 2020, was that the antibody manufacturing capacity at the Lonza Biologics site, which is abroad?

A. I think -- yes, I think there were two, so there was an initial funding ask for the AZ, AstraZeneca, antibody, and then I think there was a further ask in terms of Lonza, both of which were given approval.

Q. The final topic, please, is Evusheld.

As you told us, you left the department in January 2021, and therefore you were only in post during the first part of the Evusheld story which concerned the advanced purchase, or the prospect of the advanced

purchase.

Evusheld is a therapeutic, a medicine, which can be used prophylactically --

A. Yes.

Q. -- in advance of infection?

A. Indeed.

Q. I think described, rather wonderfully, by Dame Kate as "immunity in a syringe".

A. Mm-hm.

Q. As well as, of course, used to treat people who had become infected and ill.

And in May 2020, you received a submission concerning whether or not there should be a decision to, in principle, buy a very large number of doses of Evusheld for its use prophylactically.

And discussions proceeded, following your approval.

A. Mm.

Q. A non-binding letter was agreed, a letter of intent, and by the winter of December 2020, the VTF was on the cusp of putting to ministers and a ministerial panel an agreement to actually pay money in advance for the production of Evusheld.

You left office, as I said in January 2021. Were you aware of what happened to the Evusheld advance purchase thereafter?

A. Not at the time but obviously in preparation for this Inquiry I have looked into that. If I may just sort of say that --

Q. Please.

A. -- in terms -- actually, I think the compound was not referred to as Evusheld at the time, I think it was AZD7442, something like that.

Q. It was, and I think it was also called Project Astronaut --

A. Yes, exactly, Project Astronaut. I think for me what was very important in agreeing to that submission and the signing of a letter of intent with AstraZeneca was this was a treatment which was going to support the clinically vulnerable, who wouldn't otherwise be able to take a vaccine. I think that was very important for me.

And, I mean, you talked about Dame Kate's description, in the submission it was very clear that this could potentially provide protection within 24 to 48 hours of being administered, and I saw a great deal of advantage in that. And as I said, it was supported by Dame Kate but also the BIA. And initially I think it was a million doses that were being proposed.

Obviously, as I understand, we did actually sign this non-binding letter of indent, and the discussion continued. Ultimately, I don't think regulatory

approval came through until spring 2022, so long after I had gone.

Q. Indeed.

A. Certainly the last discussion I had on this was at the ministerial investment panel on 18 December where there was effectively reporting to ministers which said that the CMO had reflected on this particular issue and, in terms of the purchase, rather than a million, perhaps the level -- the maximum level should be 500,000, because vaccines were being rolled out, but it was still very clearly -- there was an agreement that this should be purchased to support the clinically vulnerable.

And I think that was important -- as I've said, you know, I wasn't part of the ultimate decision, and, you know, there were -- the Department of Health had experts who pronounced on why it shouldn't be purchased. But again, for me, I think if I'd been part of that decision I would certainly have asked: so what is the alternative treatment that is available to those who are clinically vulnerable if we are not going to buy the AZ treatment?

Q. If I may say so, you're absolutely right, in particular the Chief Medical Officer, Professor Sir Chris Whitty produced an advice on 10 February 2021 in which he recommended against the advance purchase, and he referred, as you say, not just to whether or not there

was doubt about the degree of clinical effectiveness, but most importantly, the fact that the vaccine programme had started, therefore there was an issue about whether or not the need for a prophylactic therapeutic was as great as it had been previously.

A. Mm.

Q. And also, doubts about the level of benefit that Evusheld would bring about.

A. Mm.

Q. But the principal point underpinning that approach was of course that there was a debate about the efficacy of Evusheld, whereas in relation to vaccines, the decision had been taken generically to purchase, in advance, at risk without knowing anything about whether or not the vaccine was even possible.

A. Mm.

Q. So it does appear on its face as if a different approach was being taken generically to the purchase of therapeutics?

A. I think the difference with vaccines was -- you're absolutely right, Mr Keith, yes, we were purchasing at a risk, but many of those candidates that we were basically putting reservation orders on, vaccine candidates, were already in trials, and, you know, if you think, from the date that the VTF was launched to

the first vaccine being administered, I think it was an eight-month period, so there was an understanding that the vaccines were coming and testing was going on.

In the case of Evusheld, I don't think phase I testing started, actually, until late autumn in 2020 and I think initially, as I remember from the submission, it had been expected that this treatment might actually be available by late autumn 2020. So I think that may have been one of the reasons why a decision wasn't felt to be imminent, because we still weren't clear in terms of the efficacy and the testing going through the different phases.

Q. I understand. As it happened, you led an oversight group, you led the oversight group on what was called the ACCORD phase II trial process, so in this pantheon of phases from phase I to IV, this was phase II.

Could we have INQ000478978 up, please.

Before the Inquiry there are number of witness statements from Professor Sir John Bell, Jeremy Farrar, Professor Sir Jonathan Van-Tam among others, who say that in relation to this issue of the phase II trial, co-ordination by the UK Government and the funders and the academic institutions which were concerned in these trials, there was a lack of coherent management. There were a lot of underpowered phase II trials, there was

a problem with recruitment.

A. Mm.

Q. There appeared to be quite a high measure of discord as to who was going to get what funding, who was going to run each of the trials, and Sir John Bell says the process became overly complex, not effectively coordinated or organised. And he describes how there were meetings with you, or perhaps in advance of meeting you in the department in which the advisory group held their corporate heads in their hands, because of the complexity of this process.

In this document headed "ACCORD new wave of trials", your officials refer to a meeting that you were going to have with Sir Mark Walport, CEO of UKRI, Jeremy Farrar, the well-known industrialist and scientist, Sir John Bell, who was intimately involved in the Vaccine Taskforce -- the Therapeutics Taskforce, and Jonathan Van-Tam, the Deputy Chief Medical Officer. And they are discussing, or you're intending to discuss proposals for the co-ordination of the new wave of Covid-19 therapeutic trials and the establishment of a new, single-delivery framework. And over the page we can see some handwritten notes which we think are yours.

A. Mm.

Q. Are they yours?

A. Yes, they are indeed.

Q. "Noise with accord very unhelpful". "RECOVERY" -- that is a reference to what was an extremely successful phase III trial, RECOVERY.

A. Yes, indeed.

Q. Same programme, I think it may be same programme or similar programme?

A. Single programme, I think. Forgive my handwriting.

Q. No, no, no, that's quite all right. You've been good enough to write everything in capitals so that's helped us a great deal.

There's a reference to funding and NIHR, the National Institute for Health Research. And then you say on the far right-hand side of the page "SIT in BEIS".

A. Mm.

Q. So is this the positions: that it was apparent by the summer of 2020 that there were going to be, well, there were problems concerning the co-ordination and management of this particular but really important part of the clinical trial process and in particular its funding and constitution?

A. Mm.

Q. Do you know whether or not the problems you identified were ever resolved, because it doesn't appear as if they

were?
A. Yes. So firstly, just in terms of these notes I think I would describe them as, sort of, absent-minded doodles during the call of the 22nd.
Q. Lord Sharma, you don't need to justify them --
A. But I think it's important to set out, you know, that this is basically what I was being told on the call, and if you look at the initial summary, it talks about, you know, what the oversight should be, et cetera.

But I think it's important to set out the history a little bit on this, Mr Keith, which is that I think there was some sort of question in terms of where the phase II trials should sit in the first place, and this was a discussion that started in March. You know, ultimately, I think Sir Mark Walport was keen that they sat under the UK research -- UKRI, and I was -- and this ACCORD programme was formed on 14 April. I was first, sort of, made aware of all of this when I was approached by Number 10 towards the end of April to ask, request that I chair this oversight board, because clearly there were issues and they wanted someone to come and at least try and bring some coherence to this.

We had the first oversight board meeting on 27 April and I think you're absolutely right, the issues became clear in terms of things not working, sort of fairly

early on and one of the key issues, as you identified, was around -- I mean, not just co-ordination but also all of that leading to not enough patients coming into the clinical trials.
Q. The recruitment issue?
A. The recruitment issue. And I think during that period of May, I think it wasn't as if people were, sort of, standing still; there were lots of plans being worked up in terms of how you get more patients, how you expand the hospital sites where you recruit patients, and I was told that there were two key issues: one is that hospitalisation rates from Covid were dropping which, you know, generally is a very good thing but obviously if you're looking to do this kind of clinical testing that presents an issue in terms of the population that you can access. And secondly, that there was a, effectively a sort of competition with some of the phase III trial phases as well.

I remember asking, and I think it says this in the minutes, on 11 May we had -- we had very regular meetings of this oversight group, and on 11 May, I think the minutes show that I asked very clearly a number of times of all the experts around the table: is there anything else that they wanted government to do to fix this issue? And I was told at the time that actually,

you know, things were in play, it would sort of resolve itself. But I think, you know, towards the end of May it was very clear it wasn't going to. And I think then at the start of June I contacted 10 Downing Street and suggested that we needed to find a different way of doing things and that ultimately then resulted in this meeting on the 22nd bringing the key parties together, and I think there is an email you will find from my statement which my private office sent to Number 10 Downing Street on 25 June which set out that I had managed to gain consensus from, you know, all of these individuals who, you know, experts in their own rights, and obviously, you know, a different set of personalities --
Q. I was about to say: it's herding cats?
A. I would never describe something like this as, sort of, herding cats. I mean, these were experts and they had differing views but I think the point is that by the end of June we had reached the consensus that this needed to be rolled into the RECOVERY trials and that's what happened.
MR KEITH: Thank you very much. That's extremely clear.

Lord Sharma, those are all the questions I have for you. But there are number of questions from, as my Lady will tell you, the Core Participants.

LADY HALLETT: Mr Thomas. Mr Thomas sits over there, Lord Sharma.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good morning, Lord Sharma. Can you hear me?
A. Yes, I can.
Q. In October 2020 your department published a press release entitled -- sorry, forgive me, Lord Sharma. I should introduce myself. I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations. I do apologise.

In October 2020 your department published a press release titled "Ethnic minority communities and the elderly called upon to bolster the fight against the coronavirus". The release went on to say that researchers were specifically calling on more people from black, Asian and minority ethnic backgrounds to take part in clinical trials for vaccines, noting that they were underrepresented at the time despite being disproportionately affected by Covid, and that at that time, only 7% of volunteers were from ethnic minority groups.

A further report from the Vaccine Taskforce in December 2020 showed that little progress had been made by the December and stated that only 8% were from ethnic

minority groups which does not reflect UK demographics.

Lord Sharma, do you accept that there has been a longstanding issue with ethnic diversity within clinical trials that remains unresolved?

A. Firstly, thank you for that question. And I think you're absolutely right, is that there was underrepresentation in the trials from, you know, the range of ethnic minority communities, and you've talked about the percentages that there were, and that percentage is obviously, you know, I think half of what the actual proportion of ethnic minority communities in the United Kingdom is.

At the time, I think there was effort made from the VTF and others in terms of messaging to ensure that we tried to get a clinical trial cohort which was representative of the UK population. Clearly, as you set out in the figures, that didn't happen, and I think one of the learnings we should take from this is that how, in future, we fix this issue.

Now, we had a registry at the time, there is a new registry that is, I think administered by the NIHR, the Department of Health. And I think one of the things that we should be thinking about is how, you know, as time goes on, we try and find a way of connecting with ethnic minority communities and other groups that were

somehow underrepresented in these clinical trials.

Q. Can I come on to that. I just want to piggyback on what you've just said because during the course of this week we've heard a lot of evidence so far in relation to historical mistrust amongst certain communities, how certain communities have been left behind. And so I suppose the follow-up question is this: given the fact that there was mistrust within certain communities and other barriers to participation, how were these being addressed?

A. So, I mean, I just want to reflect on the impact film, I think it was particularly powerful, where we had a doctor who was -- from the ethnic minority community who talked about the fact that she obviously, as a doctor, encouraged people from the community to take up the vaccine, but also was someone who was then volunteering to administer vaccines, and I think there was a discussion as well on the impact film that mosques were used as centres for vaccination, and that provided a lot of confidence.

I think, you know, in terms of getting more people from ethnic minority communities as part of that clinical trial registry for the future, I think we need to think about how we do that outreach now in terms of going into those communities and explaining to them why

it's important for them, for their children, for the community and the wider population in the UK that they are part of, you know, this kind of process going forward.

Q. Can I move on to my next question, which is this: we would quite like to know what steps did you personally take and/or oversee to increase representation and diversity in these trials for the Covid vaccines and therapeutics?

A. Well, obviously, I was a part of the information that went out in terms of press releases. You know, ultimately I had responsibility through some of the work that the VTF was doing in terms of disseminating information around this issue but, you know, it was a really challenging time and I think we all, sort of, understand that, and in a way, this is the sort of work that we ought to be doing now rather than necessarily in the heat of the moment where I think people tried very hard to try to make sure that we had a representative cohort within the clinical trials. I don't think it was for want of trying but I think, you know, you talked about building trust; that's something that needs to happen now, not in the middle of an emergency.

Q. Yes. Lord Sharma, I agree, for what it's worth, but can I just add this: bearing in mind that there was

historically a lot of mistrust beforehand, do you have any idea why that trust hadn't been built beforehand?

A. I mean, forgive me, I can't sort of comment on, you know, the work that was done in prior years when, obviously, I wasn't in post. But as we've heard from Mr Keith and the Chair, I mean, this is about lessons and learnings for the future, so I think this is, for me, this is one of the key learnings, as well: is to make sure that we can stand up a clinical trial platform which actually does everything from, sort of, phase I onwards for the future, and making sure that we are, sort of, ready to go in terms of having that representative group.

And that clearly needs work and proactive work, and I hope that's one of the things that will happen.

Q. Well, you very nicely bring --

LADY HALLETT: I think we are going to have to move on, Mr Thomas.

PROFESSOR THOMAS: Yes.

You very nicely bring us on to my final question --

LADY HALLETT: Well, I think we've covered your final question, I'm really sorry.

PROFESSOR THOMAS: So be it.

LADY HALLETT: We're so tight for time today.

PROFESSOR THOMAS: Thank you, my Lady.

LADY HALLETT: Mr Wagner. Where have you gone? Oh, there you are.

Questions from MR WAGNER

MR WAGNER: Thank you.

Good morning, Lord Sharma, I ask questions on behalf of Clinically Vulnerable Families. I'm just going to ask you about one area, if I may, which is prophylactics.

At page 77 of your statement, you've said you're not able to assess the relative prioritisation of vaccines and therapeutics because your work was focused on the Vaccine Taskforce and you weren't involved in therapeutics, and you've also suggested you're not in a position to assess the overall prioritisation of pre-exposure prophylactics.

Now I think you have discussed briefly with Mr Keith KC this morning that some prophylactics, particularly antibody treatments, were included in the remit of the Vaccine Taskforce; is that fair?

A. Yes, absolutely.

Q. Given that, that the Vaccine Taskforce had antibody treatments in its remit, and you were the chair, how is it that you, as the former chair, are not able to provide a view of the relative prioritisation between vaccines and prophylactics?

A. Well, I think that the question I was asked originally by the Inquiry was the comparison between vaccines and therapeutics overall, and given that I wasn't responsible overall for therapeutics, and neither for the Therapeutics Taskforce, I didn't feel able to give a view.

But I think if you -- if we are sort of comparing sort of the vaccines work with the work on antibodies, I think there was clearly work done on antibody treatments to support the clinically vulnerable, and we see this in terms of the, you know, agreement to fund for, you know, what became known as Evusheld.

So I think there was thought going into this and I think Dame Kate particularly was very keen when there was a sort of division of labour in terms of what the VTF should be responsible for. I think the -- I mean, I remember from the time, and the records very clearly show, that she felt that antibody treatments should be part of the VTF's remit.

Q. Although they were part of the remit, would you agree that, looking back, they formed a -- they sort of came underneath vaccinations in terms of the prioritisation, the amount of resource, the amount of creative thought, all of that that went into the two different areas?

A. No, I'm not -- I mean, forgive me, I'm not sure that's

entirely fair, in the sense that there was work being done on this area. And I said, I mean, the evidence for that is the submissions that came on Evusheld and subsequently further submissions that came to me for antibody manufacturing capacity abroad as well, in terms of securing that. So there was clearly a lot of thought going on on this, and, you know, obviously Dame Kate when she gives evidence will, I hope, sort of say the same thing. So there was a lot of thinking going on.

I think there is a wider issue which Mr Keith raised as to what happened at the end of the day in terms of the decisions on purchasing those sorts of treatments.

Q. Particularly Evusheld.

A. **(Witness nodded)**

MR WAGNER: Thank you.

LADY HALLETT: Thank you, Mr Wagner.

That completes our questions for you, Lord Sharma.

I've no idea if we're going to have to ask you to help us again in any other module, but thank you so much for your help so far.

THE WITNESS: Thank you. Pleasure.

(The witness withdrew)

LADY HALLETT: I shall return at 11.35.

(11.16 am)

(A short break)

(11.35 am)

LADY HALLETT: Mr Keith.

MR KEITH: My Lady, the next witness is Clara Swinson, please.

MS CLARA SWINSON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

LADY HALLETT: I hope we haven't kept you waiting too long.

THE WITNESS: Not at all.

MR KEITH: Good morning. Could we commence your formal evidence, please, by asking you to give your full name.

A. Yes, Clara Jane Swinson.

Q. Thank you very much for attending today, and for the enormous assistance which you and your department, the Department of Health and Social Care, have given to the Inquiry.

You personally, with the assistance no doubt of your departmental colleagues, have provided three very large, very long witness statements, but we're very grateful to you for them. Worryingly and terrifyingly, they are your sixth, seventh and eighth witness statements, INQ000474334, INQ000474335 and INQ000474333.

A. That's correct.

Q. Dated, all of them, September last year, but they run to many hundreds or hundreds of pages.

But, as I say, they're extremely helpful, so thank

you.
A. Thank you.
May I just start by expressing my deepest sympathy for those who have suffered in the pandemic and continue to suffer, and indeed my thanks to all of those who have helped make the vaccines and therapeutics programme a success.
Q. Of course.
By the metric of the need to protect at a population level against the SARS-CoV-2 virus, the evidence appears to suggest -- provisionally, of course -- that the vaccine programme was an overwhelming success and, perhaps to a slightly lesser degree but no less importantly, the therapeutics programme bought about great benefit.
The DHSC was one of many government departments entities, people, agencies, advisory committees, who helped bring that about, and it might be said to be the centre of the web in terms of the vaccines and therapeutics story. Therefore I'm sure you want to pay tribute to all of those who contributed to that larger successful outcome, but in particular your colleagues in your own department, who plainly worked extremely hard for a very long period of time in the aid of the United Kingdom.

A. Absolutely, I do, and, indeed, to many people, the experts, independent experts, who gave voluntarily of their time, and the public as well.
Q. I want to focus today on that number of discrete but no less important issues in respect of which one might say that it's important to embed the lessons about what went well, as well as to identify those areas that didn't work quite so well and in respect of which it is perhaps even more important that we try to identify what can be done in the future to make that process work better.
You are currently, and you have been since November 2016, the Director General for Global and Public Health at the Department of Health and Social Care.
A. I was since that time -- until September of last year, but I now work for the Cabinet Office.
Q. Congratulations.
LADY HALLETT: Second Permanent Secretary and head --
A. Correct.
LADY HALLETT: -- of Mission --
A. Correct, yes.
MR KEITH: I'm very sorry I haven't reflected that in my opening gambit, Ms Swinson.
The ministers in the DHSC included, of course, Mr Hancock, Mr Javid, I think Helen Whately,

Nadine Dorries, Lord Bethell and a number of others. And plainly the DHSC had a very wide remit, it was a particularly complex departmental structure which was prayed in aid of the pandemic response.
Could we just have a quick look at some of the roles that your department carried out.
INQ000474334, page 7, at paragraph 18. We can see there you've identifying at very broad level the roles of your department in: research and development; amending the legislation; deployment, you led the preparation for and facilitated the deployment at scale, although operationally, of course, deployment was largely for the NHS entities across the United Kingdom as well as national public health agencies.
Authorisation and approval. We'll come to the process by which approval and authorisation was given for vaccines later.
The approach of prioritisation. You commissioned and responded to the advice of the independent statutory body the Joint Committee on Vaccination and Immunisation, but it gave advice to, which ministers agreed, largely, I think, in advance that they would agree to, when given by the JCVI.
International engagement and collaboration; campaigns and communications.

Perhaps over the page, if there are more -- yes. Further down the page: vaccine security; vaccine uptake. You obviously contributed to the identification of areas where more could be done to ensure uptake and reduce barriers to access across UK collaboration, interaction with other vaccination programmes, holding the health system to account.
And last, but by no means least, briefing ministers.
A. That is correct.
Q. I think the DHSC prior to the establishment of the Vaccine Taskforce, was immediately instrumental in the early vaccine research and the clinical trial process, dealing with issues such as building capacity and considering development and manufacturing. So from the very word go, the DHSC was intimately involved in the vaccine and therapeutic story, if I may call it that.
A. Yes, that's correct. I think the first meetings that we had in January 2020 under the leadership of the CMO and the Deputy CMO included the need to start work on finding vaccines and therapeutics to address the new virus.
Q. Was a new directorate in fact set up in the DHSC, in your department, to deal with the vaccines response particularly?
A. That's right. In the course of 2020 a new directorate

on the overall battle plan, one on vaccines, one on therapeutics, and one on the non-pharmaceutical interventions that we heard a lot about. This module is also -- and obviously the strategy was to find the pharmaceutical interventions of vaccines and therapeutics so we could move away from the NPIs.

Q. And Antonia Williams I think took on the role of being the Covid-19 vaccine deployment director?

A. Correct.

Q. And you've provided some detail about the number of staff and the officials who were concerned in the DHSC in that directorate.

How many, in terms of full-time or equivalent full-time staff were there in -- at various times in the pandemic in that directorate, dealing with vaccines?

A. Yes, um, probably up to about 80. I don't know exactly. And about the same on therapeutics. It's varied a bit over time.

Q. The VTF was set up, as we've heard from Lord Sharma, by BEIS, B-E-I-S. But there appeared to be some debate as to whether or not that body should be accountable to both BEIS and your department, the DHSC. And as we'll see in a moment of course, the Therapeutics Taskforce ultimately did become exclusively a DHSC-led body.

A. Yes.

Q. In hindsight, do you think that was the right course, to have the Therapeutics Taskforce in DHSC and to have vaccines in BEIS?

A. Yes, I mean, the most important thing I think is that they were well resourced, they had the right expertise wherever they sat, but in setting up the Vaccine Taskforce under the leadership of Kate Bingham from May 2020, making that a task that was just vaccines not therapeutics, gave a focus to that, and therapeutics and antivirals were given their own focus a year later, and just in terms of the steps, there was a lot to do on research. There was then a lot to do on the development of vaccines and therapeutics. Then on procurement. And then on deployment.

And so the taskforces played their own role in some elements of that but weren't -- the Vaccine Taskforce was not end-to-end; it really focused on the procurement, the development, and working with industry.

Q. Why wasn't there an external head for the Therapeutics Taskforce in the way that there was, plainly, for the Vaccine Taskforce, whilst at the same time later, there was an antiviral taskforce which was headed by, I think, an external head, Eddie Gray?

A. Correct.

Q. How did that come about?

Q. How did that debate come about? Why did it matter in which department any particular advisory body or taskforce should sit?

A. Yes. So, you're right, I mean, work on vaccines and therapeutics started from the beginning, it didn't await the setting up of the taskforce. On the whole, the system you set out, people in the system did the jobs that they were already doing but at greater scale.

There were a few cases, and vaccines and therapeutics were some, where an additional organisational structure was set up because of the importance of that. There was some debate, obviously, on the -- as it was right at the beginning, research and manufacturing are more in the business department at that stage, and so it was decided by the Prime Minister that the Vaccine Taskforce would be part of BEIS therapeutic stage with the Department of Health and Social Care as you set out.

Q. So there was a prime ministerial decision ultimately?

A. Correct.

Q. Of course the production and manufacture of therapeutics involves the same scientific and innovative working patterns. It obviously is intimately concerned with the issue of bioresearch?

A. Yes.

A. Well, I think at the start, whether Kate Bingham's taskforce would cover both was under debate, when it was decided not to, there was some debate and there was definitely a lot of external input to the Therapeutics Taskforce and indeed a lot of work that Jonathan Van-Tam had already, the Deputy CMO, had already started. There was a lot of external input, whether an external chair would have changed that a lot, I don't know. I don't think it made a difference to the work of the Therapeutics Taskforce in its first year, which was largely set up and guided by Jonathan Van-Tam and I should have mentioned earlier, not just the CMO, but Patrick Vallance, the GCSA, who I think made the advice of the Prime Minister both for the Vaccine Taskforce, and the following year for the Antivirals Taskforce, that they should have an external chair.

Q. Ms Swinson, it appears to be generally recognised that having an external head in the form of, as it happens, Dame Kate Bingham, was a good thing. Bringing that very visible external leadership had very significant benefits in terms of the management of the operation and the outcome of the Vaccine Taskforce. So just in principle, would that not be a sensible thing in the future to do in the event that a Therapeutics Taskforce has to be recreated?

A. Yes. As I say, I think the biggest difference is that it has the right expertise. As we'll come on to, I'm sure, the Therapeutics Taskforce in its first year or first few months was largely -- the thing that would have the biggest difference was repurposed therapeutics that already had authorisation. So the task was slightly different than starting right at the beginning, where we didn't have any vaccines at all.

But yes, the extent of external input but also a voice, as you've said, is a judgement and could have easily also had an external chair.

The other taskforce that was set up was the testing taskforce with an external chair in that year.

Q. Lord Deighton --

A. That was -- (overspeaking) --

Q. Baroness -- (overspeaking) --

A. PPE as well under Lord Deighton for -- (overspeaking) --

Q. Lord Deighton for PPE and Baroness Harding for test and trace.

And so that we're clear, obviously the Vaccine Taskforce had within itself, very able civil servants who worked alongside the external professionals who had been brought in.

A. Absolutely right.

Q. And the Therapeutics Taskforce, was that also

a combination of external professionals and scientists and industrialists and venture capitalists and civil servants?

A. Yes, both of them were multi-disciplinary teams with commercial expertise, policy expertise. For most of the work with industry, that was done through external advisory groups rather than paid positions in the taskforce but it was the same mix of experience within both.

Q. In your statement you have equally set out in relation to therapeutics the roles of the -- the functions of the department. Just before I show you what you've said, what do you say to the suggestion that therapeutics and, in particular, prophylactics and, in particular, antivirals, were given any less attention by your department than vaccines?

A. So, from the start, with no therapeutic and no vaccine for Covid-19, both were given -- the task was to find effective preventative or treatments that would mean that science, as it has for almost all pandemics, would give us a way out of the pandemic. And that could have been a vaccine or a therapeutic or, more likely, a combination of both, from the start, that's what the Deputy CMO set out to do. They were both equally important at that stage, we didn't know which it would

be or what combination and, indeed, given there hadn't been a vaccine against any coronavirus, the very expert opinion thought that the chance of an effective vaccine was somewhat below 10%, so they were both very important from the start.

It was unprecedented, the speed of the development of the vaccine, and so by probably the late summer/autumn of that first year, 2020, it was evident that an effective vaccine was much more likely, and that did change the context, as we'll come on to, for both other preventative treatments because there would be an effective vaccine, but still really important to develop the therapeutics for those who were in hospital and in the community, that were both repurposed existing therapeutics and novel therapeutics which did come the following year.

Q. Counterintuitively and rather bizarrely, perhaps, the more successful the vaccine programme was and turned out to be, on one level, the more reduced the need became for there to be therapeutics, because of course the vaccine programme and its success reduced transmission and at a population level reduced the spread of the Covid-19 virus for which therapeutic treatment would be needed to deal with.

And also, as the vaccine programme began to succeed

at a remarkable and at such a high level, there were fewer hospitalisation cases and fewer people available and willing to have therapeutics tested on them anyway. So there was that problem built into the success of the vaccine programme.

A. There was that impact, yes, whether it was a problem or not, the numbers that we needed for research, you're quite right, is one reason why, in the UK, so many people successfully enrolled in research in that first year. Of course, the chief investigators took or carried out research both in the UK but in other parts of the world, and did need people who were infected with the virus, at whatever point that was, in different countries. So there were various trials done in other parts of the world as they were in the UK for precisely the reason you set out.

Q. I wasn't going to ask about trials, but you've raised a point that I'll just ask you about.

A. Yes.

Q. Just a few moments ago to Lord Sharma, Leslie Thomas KC put a question about the lack of diversity in the clinical trials for the vaccines. But of course, what hasn't perhaps been made sufficiently clear, is, there may have been a lack of diversity racially and ethnically in trials in the United Kingdom where

I think, in very broad terms, the clinical trials for vaccines that were carried out in the United Kingdom had about a 7% ethnic minority make-up as opposed to a proper or a full reflection of the demographics of around about 13 to 15%.

But all the vaccines had overseas trials as well for the same product and in some countries, is this not right, there was up to an 80% ethnic or racial component?

A. Absolutely, you're correct.

Q. Because they were conducted in South Africa --

A. Correct.

Q. -- obviously where there's a very much higher proportion who are black African as opposed to white British. South American, America, and elsewhere in Europe?

A. Absolutely. So both diversity and looking where research could be done where there were higher rates of the disease, correct.

Q. Thank you. I've digressed already.

Bringing you back to therapeutics and your witness statement, can we have INQ000474335 at page 7. You set out there at paragraph 18 and paragraph 19 the areas in which the department was concerned on the therapeutics side: Research and development; procurement, storage and supply; funding; communications; engagement with the

science licences sector; working across the whole of the United Kingdom; international collaboration; briefing ministers and senior officials.

A. Yes.

Q. In terms of the width, any less wide than the functions in connection with the vaccination -- vaccines?

A. No, very similar and as for vaccines, most of the wider health system and the independent regulator and so on did exactly the job that they normally do for any vaccine or therapeutic, not just the C-19, but it was the same system, the Department of Health, because of the emergency situation obviously was more active in many of these than it would be normally, but it's across the breadth, from discovering and research into a vaccine or therapeutic -- therapeutics, sorry, now, through to deployment working with NHS England to get the treatments to the patients who needed them.

Q. May I just moment materially put to you each of the key bodies which you identify in your statements --

A. Of course.

Q. -- and just ask you to confirm their general -- as simply as you can, their role in the general scheme of things.

You're in the hot seat, Ms Swinson, because you're -- you were the Director General of Global and

Public Health and in the DHSC you're obviously able to see how the system comes together.

A. Yes.

Q. In relation to vaccines, your sixth statement, INQ000474334, page 22, page 21, paragraph 20, you identify -- I'm looking at the wrong statement.

A. That's okay. Public Health England?

Q. No, it was the right reference, it's just I had the wrong statement in front of me.

So can we have back, please, INQ000474334, page 22. Thank you.

Paragraph 70, there's a reference there to the UKHSA:

"The UKHSA is [normally] responsible for [the] procurement of vaccines for ... routine programmes."

But in the specific context of the pandemic, what it and the -- Public Health England agencies did, as did the public health agencies in each of the devolved administrations, was provide public health advice on all aspects of vaccination.

So UKHSA stood back from the role of procurement and that was largely conducted by the Vaccine Taskforce within BEIS with the assistance of the DHSC; yes?

A. Correct.

Q. There's a reference, in paragraph 71, to the Medicines

and Healthcare products Regulatory Agency. That's the UK regulator --

A. Correct.

Q. -- primarily responsible for authorisation and licensing of both vaccines and therapeutics. Is that an entirely independent agency, independent of the rest of the government?

A. Yes, it's an agency of the department but it is an independent regulator both in the way it assesses the safety, effectiveness and quality of drugs and vaccines before they come on to the market, with also the input of the commission of -- for health medicines, CHM, that advises it. And that is independent and regulates all medicines on the market in the UK.

Q. And in terms of its independence, what's important about what happened during the pandemic is, whilst it's an executive agency within the DHSC, formally, it gave independent advice on whether or not to license, authorise, every single vaccine and every single therapeutic that was licensed; and the way it would work was it would give independent advice which would then be formally, if you like, decided upon by one of your ministers --

A. Yes.

Q. -- called the Licensing Minister?

A. Yes.
Q. But that in no way detracts from the fact that it was absolutely for the MHRA to say whether any given vaccine or therapeutic should be authorised?
A. Correct. It was agreed with MHRA in the summer of 2020 that -- under the emergency procedure and one of the regulations that the same advice and work would be given -- would be done within MHRA, but that decision would be put to a minister. We identified a different minister in the department, called the Licensing Minister, to take that decision, so that it was separate from the ministers who were responsible for the supply and purchase and rollout of vaccines, so that there was no perceived conflict between those two roles.
Q. And was the DHSC and the Office of the Chief Medical Officer, comprising obviously the CMO and the DCMOs, at pains to guarantee and ensure the continued independence of the MHRA?
A. That is correct and that was set out both in the note of the meeting that I was referring to in the summer of 2020 with the then Secretary of State and the Office of the Chief Medical Officer, indeed both for MHRA and for other independent bodies. They were obviously very interested in the progress of their work but it was -- in no way took away the independence and the decisions

that they recommended.
Q. So you were constantly being informed as to progress?
A. Yes.
Q. What would have happened if those persons, civil servants and external professionals, scientists, academics, who were involved in procurement, in the procurement of vaccines and therapeutics, the manufacture of vaccines and therapeutics, the purchase of vaccines and therapeutics, or their delivery, had got involved in the MHRA authorisation safety processes?
A. So it was important we had the line between those, so that in their desire to get a vaccine, that none of that was influencing the proper process that MHRA took, and indeed that the authorisation decisions, all of those, I remember at the time, were done on a very tight copy list. There were also code names for vaccines early on so that people working on the -- preparing the rollout did not know the exact state of the work for MHRA and the authorisation that was done on an independent basis.
Q. Another important body, of course, and we've heard much of it already, was the Joint Committee on Vaccination and Immunisation.

If you could have page 30, please, paragraph 103. In relation to the JCVI, is this not just an independent but in fact a statutory body?

A. That's correct.
Q. So it actually isn't part of government in any shape or form.

Its recommendations were, of course, concerned with prioritisation.
A. Yes.
Q. Not authorisation, but the priority by which people would have their vaccines made available?
A. Correct.
Q. And did you put into place a system in which although the Secretary of State in certain circumstances is legally bound to implement recommendations from the JCVI, in the context of Covid-19, the Secretary of State agreed, because it didn't fall within those particular categories, nevertheless to give real weight to anything that the JCVI said on the issue of prioritisation?
A. Absolutely. The difference in this circumstance is that JCVI did not consider cost effectiveness because the vaccines had already been procured, but both the Secretary of State and indeed it went to Covid-O, the Cabinet Office-chaired cabinet committee, who agreed that they would take the advice from JCVI and implement prioritisation in the way that they recommended.
Q. And although it wasn't a matter for the DHSC, in order

to further promote the appearance and actuality of independence, the actual chair of the JCVI, Professor Sir Andrew Pollard, recused himself because he'd had some involvement in research work in Oxford, and that's why Professor Wei Shen Lim took over?
A. Correct, and it's exactly for that reason that I want to set out my thanks both to Professor Wei Shen Lim and all of the members of the subcommittee, which I think met pretty much twice a week and more often when needed throughout this period.
Q. I think they were on the phone to each other day and night, 24 hours a day, it would seem.

Just a quick dance through the remaining bodies and areas.

Page 33, paragraph 104. Once the vaccines were procured with the great assistance of the VTF, for the population as a whole, at what point did the UK Government step back and at what point did the remainder of the process fall within the authority and the practical reach of the devolved administrations?
A. Yes, so once the vaccines arrived in the UK, they were distributed to agreed points for each of the devolved administrations, or for the Crown Territories, Overseas Territories, and the Crown dependencies, as set out.

PHE, as was, were responsible for the logistics of

that operation, and then once it was in those places, the NHS in England and in each of the other nations were then responsible for the deployment -- distribution and deployment to the vaccination centres.

Q. And in England it was the Secretary of State, your Secretary of State, Mr Hancock until June 2021, who took decisions on vaccine deployment on the advice of PH England, UKHSA as it became, NHS England --

A. Correct.

Q. -- and the Vaccine Taskforce amongst --

A. Absolutely.

Q. -- a myriad of other bodies.

A. Yeah.

Q. And in terms of the overall co-ordination, page 80, paragraph 302, even though delivery, the output of vaccines was for each devolved administration, there was in the earlier parts of this remarkably complex machinery very close engagement at all levels in respect of all aspects of research, development, procurement, manufacture, clinical trial, and authorisation?

A. That's right, across the UK, that was both done with the UK CMOs, the DCMOs, at ministerial level and at policy official. There was very closely working -- there was slightly different statutory arrangements for the JCVI for each of the bits of the UK, but they all followed

the same advice. And where there were lessons to learn or things about where the vaccine would be rolled out or changes, that was very regularly discussed.

Q. And then on therapeutics, as I've emphasised no less importantly, your seventh statement, is largely concerned with that topic.

INQ000474335, page 9, paragraph 23.

You set out something of what was the Antivirals & Therapeutics Taskforce. Was that a combined entity that brought together the Therapeutics Taskforce and the Antivirals Taskforce --

A. It was.

Q. -- in April 2022?

A. Correct.

Q. There was, paragraph 24, an advisory committee called RAPID C-19, which comprised a number of bodies but, most importantly, NICE, the National Institute for Clinical Excellence?

A. Correct.

Q. And a number of other bodies. And it took, to a very large extent, the decision as to what particular therapeutics would be not just investigated and pursued, but ultimately made available?

A. That's correct. I said that most of the system did exactly as it did before the pandemic. NICE assesses

drugs and makes a cost effectiveness judgement and asks the NHS to make them available. That was -- there was a different system so that was done faster in the pandemic, and that is chaired by NICE. RAPID C-19 did a very similar job to what NICE would have done, or does do, in the non-emergency time, and recommend which therapeutics should be made available to the NHS.

Q. And importantly, did RAPID C-19 have membership from all of the devolved nations including --

A. Across the UK, yes.

Q. -- all the devolved administrative bodies such as the Scottish Medicines Consortium, the All Wales Therapeutics and Toxicology Centre -- (overspeaking) --

A. As set out here, correct.

Q. So that although it was a UK body, in practice and reality, as with many of these advisory committees and bodies, they included membership from across the United Kingdom, so that to a very large extent they all became trans UK bodies?

A. Yes. And had a common approach.

Q. And a common approach.

The MHRA, you address at paragraph 30. I don't think we need to dwell on that except, perhaps, 30(b). The MHRA is a UK body, is it not?

A. It is.

Q. But notwithstanding, therefore, that in terms of its authority, it extends across the whole of the United Kingdom, it also is carefully linked to NICE in England, SMC in Scotland, and the AWTTG (sic) in Wales for the purposes of its recommendations?

A. That is correct.

Q. There was a Therapeutics Clinical Review Panel, page 26, paragraph 87, which also played a role in the advice given to the -- all the UK Chief Medical Officers. So not just the Officer of the Chief Medical Officer, but in fact all four UK Chief Medical Officers about therapeutics.

There was another body, page 27, the UK Covid Therapeutics Advisory Panel, which gave independent advice for that earlier group on the most promising therapeutics, and then, as you have described, there was the RAPID C-19 process as well as the taskforces which were concerned with procurement and -- procurement.

A. Correct.

Q. Right. It's a complicated structure, Ms Swinson.

On the funding side, we've heard a bit about the funding from Lord Sharma. We're aware, of course, of the NIHR, the National Institute for Health, now Health and Care Research, the important body, the UKRI, and also the funding done by the United Kingdom Vaccines

Network.
A. Yes.
Q. It's obvious that there were a number of funders. Do you assess, by reference to the speed with which decisions were made and the number of vaccine and therapeutic trials that were funded, that that system of funding worked well in January, February, March, April 2020?
A. Yes. So on research funding I think it did work well. I'd say two things about it. One, that you've referred to, is that decisions that were taken before 2020 were very important, so the base of the clinical networks and research infrastructure in the UK, and indeed relatively small amounts of investment that made a big difference into the capabilities that the UK had and the development of the AstraZeneca vaccine at Oxford were already in place, and then when the pandemic had started, coordinating that, issuing an urgent public health call, and being able to fund and coordinate the trials in the spring of 2020, that was incredibly important, and I think worked well.
Q. Just pausing there. A great deal of research had already been done on M -- messenger ribonucleic RNA vaccine technology, so although two, I think, of the Covid-19 UK vaccines were based on mRNA technology and

were new vaccines --
A. Yes.
Q. -- the technology had been around for some time and had been funded and gone into; is that correct?
A. I think you would need someone more technical but I think they are the first mRNA vaccines at all, so it was known as a theoretical approach to vaccines that was being developed and that became --
Q. But the technology, the research, had been going on for some time?
A. That's correct.
Q. Secondly, the Oxford AstraZeneca vaccine based on an adenoviral virus, a chimpanzee virus --
A. Yes.
Q. -- known as a vector virus, again, that had been in play, not, obviously, for the purposes of the coronavirus virus that we were dealing with, but it had been in play, the technology had been in play for a while, and that had been funded for some time already by these various elements in the United Kingdom government.
A. Yes, so the UK Vaccine Network was funded from our overseas aid budget, it had been established after lessons learned from the Ebola outbreak chaired by Sir Chris Whitty, it identified viruses of pandemic or

epidemic potential, particularly in low- and middle-income countries and funded research into what was then a MERS, so it was a coronavirus, the coronavirus vaccine platform which was then -- and had had some early clinical trials, which was then able to pivot to the new coronavirus, the novel coronavirus, that had been found.
Q. Indemnities. Entirely separate subject, please.
A. Yes.
Q. Taking it briefly, because we've heard from Lord Sharma on the general topic of indemnities already.
You were directly concerned with drafting submissions to the Secretary of State seeking authority for the general approach taken by the UK Government --
A. Yeah.
Q. -- both in general terms to indemnities but also in respect of each of the contracts.
A. Yes.
Q. Was the nature and the style of the indemnity in each case negotiated with each manufacturer separately?
A. I believe so. It was the responsibility of the Vaccine Taskforce with very significant commercial expertise, and I think it's not unusual in an emergency situation to have these types of indemnities. They advise the ministerial panel, which was the Minister for --

Secretary of State for Health, and for Business, as well as ministers from the Cabinet Office, and Treasury, about those decisions, and we also advised our Secretary of State, as set out, when the UK Government takes on indemnities, there's also an obligation to inform Parliament, which we did following those submissions and whenever we deployed a vaccine, updated those liabilities to Parliament.
Q. The overall approach to indemnities was put to and agreed by the Prime Minister, given the significance and the amount of public money concerned.
Why was the DHSC involved in this issue when it was BEIS and the Vaccine Taskforce that were leading on the negotiations? Or were you involved because your Secretary of State, Mr Hancock, was on the ministerial panel?
A. Yes, I think a few reasons. That is certainly one of them. I think it might have formerly reported to both departments from 2020 -- later in 2021 and for the relevant accounting officer, which at the start was in BEIS but then transferred to DHSC, that's the issue I talked about, about ensuring that spend was regular and proper and indemnities could be informed to Parliament.
Q. Well, when you were briefing your Secretary of State, as

is the way with government, you put a handful of hypothetical questions and answers to him, for his consideration, by way of trying to foresee what sorts of questions the public might ask about what had been agreed by the UK Government. And one of the questions which you invited his approval for, in terms of alerting him to what might be said by sectors in the public, was "Why are you letting big pharma get away with the delivery of a potentially unsafe vaccine by protecting them from civil liability?"

In general terms, were the indemnities agreed by the UK Government designed to, or did they, protect the manufacturers from actually being sued in the courts by individual claimants?

A. No, they were very specific, and I think it was common across most international countries that at the time we were procuring it was normal, we had -- so it's rare, but, for example, we had done the same in the H1N1 swine flu pandemic, to -- at that time, to offer a limited set of liabilities to the manufacturers that the UK Government would take on.

Q. So there was no overarching statutory immunity to the effect of you can't be sued?

A. Not at all.

Q. There was no guarantee or any provision given by the

UK Government generally limiting access to the court. It was only about agreeing to pay in the event that a manufacturer lost in the civil courts, on a claim perhaps under the Consumer Protection Act, by way of reimbursing the manufacturer for any award of damages made against it and any legal costs, in certain circumstances?

A. Yes, I think that's right. BEIS and the VTF would be best placed, but that's roughly right.

Q. All right.

Moving on to the authorisation process.

A. Yes.

Q. It's well known that, in relation to the vaccines authorisation process, instead of waiting, which is usually the position, to the end of all the phase I, II and III clinical trials for all the data to be given to the MHRA as part of an application of authorisation, the MHRA agreed to receive the data as soon as it became available.

A. That's correct.

Q. A rolling review.

Was this course that was adopted something of concern to the DHSC on account of whether or not it would give rise to perhaps unfounded concerns about the degree of rigour or attention being paid to safety

issues?

A. No, the rigour was exactly the same. As you said, it was the speed that allowed, instead of waiting for the entire bundle of information to come to the MHRA that would take number of weeks or months, that the MHRA assess the information as it was given to them, the rolling review as you called it, which meant that by the time the final phase III trials had been completed, and the advice, they'd already looked at what had come earlier. It was exactly the same level of scrutiny and data required for its assessment of safety and effectiveness.

Q. So was there any reduction, as the DHSC saw it, in the amount of time dedicated to clinical trials, or the number of participants in those trials, or the time taken by the MHRA to look at the data and the outcome of all those trials?

A. No, it was running various assessments and indeed trials that, in normal times, might run one after another. It was being able to run those concurrently where it was possible. It was -- also meant that the MHRA, if they had any kind of technical questions about the form in which something had been given, they would talk directly and make sure they understood it, rather than it being a kind of a slower to and fro on -- between the MHRA and

the company, so that they were able to make the assessments as quickly as possible.

The quality and the standard of that assessment was exactly the same. It was the speed and being able to do things concurrently that was different.

Q. Bluntly, the MHRA picked up the phone constantly, at all times of the day and night, to say: "What's going on?" Or "What about this?" Or "Where is that document?"

A. Exactly.

Q. "What does it amount to?"

Rather than just waiting in a delphic silence --

A. Yes.

Q. -- till the end of the process, at the point at which they would be asked to give authorisation and have all the material dumped on them?

A. Exactly right.

Q. On the topic of safety, remaining on this topic, the paperwork shows, the documents show that the DHSC was very closely connected to the general debate about the absolute importance of having the MHRA made aware of any safety concerns or issues or side effects appearing from the clinical trial process, as well as the no less important obligation to keep the public and the clinicians and doctors and professionals informed.

Is this, in reality, a very complex structure? Are

there a number of different ways in which the MHRA studies vaccines and therapeutics, and of course this system applies to both vaccines and therapeutics, for side effects, for suspected unexpected serious adverse reactions? And also a no less complex structure by which it puts all information into the public domain?

A. Yes. Now I know you're hearing directly from the MHRA --

Q. We are.

A. -- but the -- their assessment is both of the trial data, so that is both laboratory data and trials in humans, and their assessment of that. When they come to authorise, they set out any precautions or things that need to be said in the patient information leaflet. They also look at the quality of the actual drugs, so they will do regulatory checks at the manufacturers, that they batch test each batch of the vaccine before it comes onto the market to make sure that what is being provided is as they were set out on paper. So that's the second tranche.

Then, as you say, after deployment they also do surveillance and monitoring of any side effects that are reported, any other real life data, so that they are also able to then amend any of the conditions under which they've marketed the product.

Q. And in terms of the conditions, there are formal routes by which the public are kept informed through a document known as a summary of product characteristics, also the patient information leaflets.

But the DHSC was obviously aware that the MHRA had a number of different routes by which it kept the public informed in addition. So there were weekly publications of information from the Yellow Card system?

A. Yes.

Q. There was something called a drug analysis profile published regularly in respect of every vaccine, and changes made to the medical bible, the Green Book, as well as press releases, publications, and the like?

A. Yes, all of those ways.

Q. Was there ever a time in which you, as the Director General of that directorate, or the Secretary of State, or any of the DHSC ministers, perceived that there was information about side effects or the safety or the overall safety, or any kind of suspected -- because obviously you don't know whether or not a condition is associated with the vaccine, associated with the virus, or coincidental -- but any suspected condition was not being put into the public domain?

A. So, in terms of MH being in close contact with MHRA and the experts, also via the Chief Medical Officer and

Jonathan Van-Tam, knowing what they were doing, the safety signals, which I think MHRA confident always reported as soon as they had information -- communicating risk to the public in terms of any change that's happened is a complicated thing to do, so when there were changes on the AstraZeneca vaccine and then on the Pfizer BioNTech, working closely so that MHRA, the JCVI and, if required, the Deputy Chief Medical Officer, could set out that information not just in writing and on the website, as you've said, but in a press conference or whatever was needed, that was brought together if it needed to. So it wasn't just from one individual organisation.

Q. Let me put it another way. Did you or your team or your officials or your colleagues ever have a situation in which they became aware of a specific safety risk or a condition or a suspected adverse reaction in relation to any of the Covid-19 vaccines which didn't subsequently, following examination by the MHRA and the Commission on Human Medicines and panoply of government agencies, reach the public domain?

A. No.

Q. Prioritisation. It's obviously a matter for the JCVI primarily, because you've described how your Secretary of State agreed in advance to accept recommendations

from the JCVI, but did the DHSC differ significantly or did it depart significantly from the general approach agreed by the United Kingdom, which was that the priority list had to be based on the essential clinical feature that the oldest were the most vulnerable and had to be vaccinated first, along with care home workers who looked after them?

A. No. JCVI put out their initial assessment or prioritisation early on in 2020. There were some new -- that became more -- it was an iterative process about exactly what the groups were, but it remained roughly the same. We were not concerned about that.

There was, I'd say, two things: there was quite a lot of debate, I mean publicly and around government, about whether different occupations or there should be a different way of looking at it, other countries also sometimes did different things so why that was the case. But the JCVI always looked at the clinical vulnerabilities, it was set out in that way, and I think any of the questions put to them addressed that, that age was by far the biggest predictor of serious disease. So I'd say that, in terms of the process.

I'd also say that, you know, there were concerns about how people would react, the population as a whole, to the prioritisation. I'd say because the rollout was

so quick -- you know, if it had been going on for months and years I think there would have been more debate but because it was offered, you know, by Easter to all the over-fifties and those clinically vulnerable and then to all adults being offered a vaccine really by -- within seven or eight months, I think it also meant that people were confident that not just the prioritisation was correct, but also that the NHS would get through that very quickly and everyone could take up their offer of a vaccine.

Q. And in an overall sense, I think the priority groups were all offered, at least vaccination, in every country in the United Kingdom by, well, four dates in March and April?

A. Yeah, it was an amazing achievement.

Q. It is self-evident that with respect to a virus which kills the elderly first and most quickly, and therefore makes them the most vulnerable, that any consideration or prioritisation should probably focus on the elderly. But did the DHSC and the JCVI also have recourse to mathematical modelling which established that if you offer vaccines to the older age groups first, you will inevitably end up reducing the total number of deaths which will be suffered by the United Kingdom?

A. Absolutely. So the policy intent given to JCVI was to

reduce mortality and morbidity as quickly as possible. In doing that, they've had access to epidemiology, clinical information, also modelling. This came into its own also when they looked at the dosage interval early on and decided that the best way to protect the UK population was to get as many people their first vaccine dose, rather than -- and prioritising that within the window above second doses.

Q. You've mentioned the difficult issues of whether or not you interpose particular occupations.

A. Yes.

Q. Put them further up the priority list or put them into the priority list. And we'll ask other witnesses of the pressures that were brought to bear from particular sectors to have their members vaccinated as a priority.

But more widely than that, were there quite acute ethical issues concerning the need to prioritise the vaccination of those who worked in jobs that can't be done at home: persons in ethnic minority communities, I don't know -- younger adults. There were some quite difficult issues to be resolved. Did the DHSC seek advice from its advisory group MEAG, the Moral and Ethical Advisory Group, on these issues?

A. It did, yes.

Q. And do we take it from the fact that the priority list

was still age-stratified that, by and large, the advice that the DHSC received was that the age approach had to be maintained?

A. Yes. There were a number of other factors, as you set out. They were very carefully considered by JCVI and others, including our Moral and Ethical Advisory Group. The assessment of the clinical vulnerability was that age was by far the biggest predictor and so therefore, for people in different occupations, different settings, they would have access to the vaccine according to age order, unless they had a health condition that put them in groups 4 or 6, or priority groups 4 or 6 of the JCVI.

Care home workers and healthcare workers had been considered and were prioritised in groups 1 and 2 from the start.

Q. And we'll look at that with Professor Lim.

Presumably the advice that you received was that if you vaccinate those who are most at risk in terms of morbidity or mortality, those who literally will die first if they're not vaccinated, and the quicker you get through those cohorts, the quicker you'll get to the point at which transmission across the country as a whole is reduced and the risks to everybody are indirectly reduced. Is that the thinking?

A. Yes, for vaccine effectiveness, you both look at the

impact on the severity of the disease as well as transmission, and that changed a bit over time with the different variants and the different vaccines, but being able to offer the vaccine to reduce mortality, reduce the risk of hospitalisation by a very large percentage, I think about 80%, both reduced the pressure on hospitals, it saved lives, thousands of lives, in that first year and subsequently, and indeed, brought down the peaks of the waves of the virus.

Q. There was a particular issue concerning prioritisation and you've referred to it already, and that was cohort 6, priority group 6. That cohort, that group had in it a footnote or a reference to carers. And an issue arose as to whether or not, in group 6, unpaid carers should be approached on the basis that they were to be included in the definition of sole or primary carer --

A. Yes.

Q. -- to which cohort 6 footnote or text referred?

A. **(Witness nodded)**.

Q. Ms Swinson, the material does appear to make plain that government at some stage, and at some point, was concerned that if the definition of carer was expanded over much, it would mean too many people being given priority vaccination. At the same time, you're obviously concerned to ensure that the prioritisation

groups followed as swiftly as they possibly could. How do you assess that problem was -- how well was that problem resolved by the DHSC?

A. Yes. So when JCVI recommended cohorts, or groups to go into the priority 6, there was then detailed work in the department and in the Green Book, as you've referred to, about the definition of those groups, so defining them, how to define a healthcare worker, how to -- a carer. There were some ways that that was done that were straightforward, for example being in receipt of Carer's Allowance. There was also a carers register. And I think what then also happened so that people who hadn't -- who weren't registered in that way, if they were the main carer of someone who would be at great risk of Covid-19, that could also be agreed through primary care through your GP surgery.

So defining that cohort and exactly who had eligibility was carefully considered, and the definitions were put in the Green Book.

Q. In hindsight, do you think the government took a too narrow view of the definition of carers? The upshot was that a very large number of unpaid carers did not receive prioritisation -- prioritised vaccination in cohort 6.

A. Yes.

Q. Was that not an error?

A. I don't know the numbers, but obviously you were offered a vaccine both -- or the offer was both to sets for carers but it would also be age-related, so, you know, a relatively elderly carer for -- caring for an older parent would also have access to the vaccine through the age route, and I think -- I don't remember it being a large issue, but locally it may well have been and people should have talked to their vaccine centre.

JCVI did set out that there was operational flexibility, so if someone had gone for vaccination with their carer and there was a spare vaccine, because we were very much looking to minimise wastage at the end of the day, there were other ways to make sure that you could get the vaccine.

Q. The DHSC was concerned -- it was involved because although prioritisation was for the JCVI, the JCVI would reach out to the rest of the government when there were problems about the meaning to be given to the text --

A. -- (overspeaking) -- yes.

Q. -- or the priority groups, or how operationally it was to be put into practice. Was that why the DHSC was engaged?

A. Yes, I think that's right, and for both cross-government but also the response from the public, it was important

that there was continued confidence that it was being done in a fair -- the rollout was operating in a fair way.

Q. There was a considerable diminution and reduction in confidence amongst that cohort because of this -- and it was a problem. There was a real issue as to whether unpaid carers would get prioritised. Do you think --

LADY HALLETT: Can I just interrupt -- I'm so sorry. Keep that train of thought, Mr Keith.

Just going back to you said that you could go to the local vaccination centre if you thought you ought to be given some priority. But did people know that? I don't think I realised that if I -- actually, I think I was in one of the groups that got the jab quite early, but I don't think people knew that, did they?

A. I was referring, really, to the operational flexibility that centres did have, at the end of the day, for healthcare workers. JVT has set out in his statement, for example, when he was vaccinated. The fair and agreed rollout was through the JCVI age cohort, and I think there were very many, you know, big campaigns about -- both publicly when you were eligible, but also through emails and texts and other ways.

LADY HALLETT: Have you still got that thought, Mr Keith? I hope you haven't lost it.

MR KEITH: No, I hope so.

I was going to ask you -- thank you very much.

Do you think that the problem of identifying who or what type of carer would fall within a particular cohort next time, and obviously the great probability is that the next pandemic and the next viral outbreak will or will probably hurt the elderly and those who need care more than most, do you think there's an argument for reform by way of having a permanent register for carers, whether paid or unpaid, so that in the teeth of a crisis the government can simply say, "Well, we know how many people we're dealing with, we can identify the cohort, this will enable us to take a view as to whether or not they should be prioritised easily"?

A. Yes, it's obviously easier to define a cohort when that list already exists, which is the case for healthcare workers. It was the same for careworkers, where we asked employees -- employers, to make sure that all of their employees, because there wasn't a register of paid careworkers, as, you know, unpaid carers can be a large cohort, those in receipt of Carer's Allowance are largely unpaid. That's a large number. If there was a way to maintain and to define -- a lot of work was put in at the time, but for any group that needs to be defined, if there is an existing register it makes it

simple. And if not, depending on the next -- what the circumstances would be, I'm sure there would be other groups that we will need to define at the time.

Q. Well, you say a lot of work was done but the truth is there was no agreement or no decision made to try to draw up a register, therefore the public had no means of registering their involvement as an unpaid carer, and therefore, nobody knew how many people they were dealing with and nobody knew whether they were entitled to prioritisation --

A. I don't know --

Q. -- if they were an unpaid carer.

A. Yes, I don't think it would have been no one but yes, I'm sure there were people, and I've seen the -- on the estimates of how big each cohort was, and how fast we could get through the cohorts, there were, you know, best efforts for what those numbers would be.

Q. You got there in the end because of course the prioritisation process reached everybody in the end, and then everybody, whatever age, got vaccinated --

A. Yes.

Q. -- or was offered a vaccination. But this was a particular cohort.

In order to address the concerns and needs of particular Core Participant groups in this Inquiry, was

particular consideration also given, through the prioritisation process, but also in terms of operational responses, to the needs of migrant people, homeless people, members of the prison population, and, in particular, whether or not there should be a carve-out for them specifically within the overarching prioritisation process? So it was -- everybody was thought about even if an exception wasn't made, ultimately?

A. Yes, JCVI looked at very many bits of evidence. There's correspondence, I know, that you have made available about their assessments for both homeless people and prison workers. And all of that was carefully considered and taken into account in the groupings, that they continued to evolve depending on the evidence.

Q. In relation to children, we're going to target our questions, in fact, to the JCVI and also the CMO and DCMO, because they're the ones who gave advice on it.

A. Yes.

Q. But as it happens, in cohort 6 were also adults aged 16-65 who were in an at-risk group, and therefore the DHSC wrote to the JCVI seeking advice in March 2021 on the topic of universal vaccination, so a widening out of the vaccination delivery programme for all under-18s.

And your Secretary of State wrote in May 2021 formally requesting advice on the vaccination of children and young people, and obviously it was a matter for which he was seeking the view of the JCVI. You, I think personally, wrote again on 23 June. The JCVI, however, didn't respond until 5 July 2021, and they gave their quite complex view as to whether or not children and young persons aged 12 to 17 should be vaccinated?

Do you know why there was that delay? For those persons who were in vulnerable households or who were immunocompromised or clinically extremely vulnerable or clinically vulnerable, they were greatly concerned at the issue of whether or not children would be vaccinated in an attempt to reduce transmission. There appeared to have been some delay. Do you know why that was?

A. So the evidence for children was -- came later than it did because they hadn't been involved in the clinical trials, it wasn't authorised for under-16s, I don't think, right from the start, or definitely wasn't. There was evidence by the spring of 2020, particularly from the United States and some other places where that could be properly taken into account, and, as you've referred to, the JC -- what happened, I think, for the under-18s is there were a number of steps, it was an iterative process, so first of all for the 16 to 18s,

then for those 12 to 15 with health conditions. From that letter, the universal offer for the 16 to 18s I think was recommended in the July, but for the 12 to 15s, that advice then came later in -- at September, which I'm sure you'll come on to.

So I think it's not so much that there was a delay in the answer; it was that the answer came in a number of steps according to the evidence, and where JCVI were confident to recommend adding children to a universal programme.

Q. Was the DHSC more concerned in the issue of vaccine uptake, and in the process for vaccine uptake, than it would normally have been concerned with in respect of routine immunisation?

A. I mean, I would -- DHSC are concerned about vaccine uptake on the childhood programmes and the impact that that has, but clearly, in 2021, the government had set out the roadmap out of lockdown and out of the restrictions. One of the tests in that was vaccine uptake because it was one of the things that would give confidence to reopen society, remove many of the social restrictions and so on. So there was definitely a very strong interest in uptake, both for the protection of individuals, the reduction of mortality, but also for the impact on society and the economy.

Q. To what extent did the DHSC and other bodies such as the CMO, DCMO, NHS, Public Health England and so on, and the VTF, consider, and if so how frequently did they consider, how to ensure the barriers to access and inequalities of healthcare service did not prevent the uptake of vaccines which were being offered?

I mean, was this something which you majored on, was this something you paid attention to? Were there daily meetings? Tell us how it worked.

A. Yes, absolutely. So it was known before the pandemic, so we knew when we were planning the campaigns that in all likelihood, because of our experience on routine programmes, that uptake in some groups would be much harder, there would be harder-to-reach groups. There were, by the time, I mean, we had daily meetings, I think from November with the Secretary of State, and that covered a range of things on supply, on deployment, and increasingly on uptake. There was Dr Nikki Kanani who was appointed in NHS England around uptake for those in harder-to-reach groups, and that was a very frequent, if not daily, conversation, and the vaccine uptake plan was published in February 2021, that set out the approach to that.

I can say a bit more about the overall approach or I'll wait --

Q. I'll come on to that in a moment.

We're going to try to not use phrases like "harder-to-reach" because of the connotation that there are groups who put themselves beyond reach.

But could you, please, have a look at the vaccine uptake plan, INQ000087230, of February 2021.

A. Yes.

Q. So within a couple of months of the programme commencing.

If we look at page 3 briefly -- this is obviously a public document -- we can see that you say, and this is a departmental document, or at least Mr Hancock said, six paragraphs down:

"We need to ensure that everyone feels that the vaccine is for them. For some groups of the population the intention to vaccinate is lower ... [We need] to make sure that all our communities are protected, this Vaccine Uptake Plan sets out our approach."

The vaccine programme had already started. There was a Vaccines Delivery Plan published also by the department --

A. Correct.

Q. -- I think a month before, on 11 January?

A. That's correct.

Q. But there doesn't appear before January to have been

a clear pronouncement by your department that it was absolutely vital to make sure that everything that could possibly be done would be done, to ensure that the barriers to access and inequalities were reduced. Why was this not put first and foremost, right at the front before you even got going with delivery?

A. I mean, the times when we published documents, as you say, both in January and February, that was covered, it was definitely part of the discussions and the Secretary of State had asked NHS England to be ready from 1 December to deploy vaccine. Everyone involved in the delivery of vaccines, and NHS England and directors of public health would know that different groups needed particular different approaches, even when there was a universal offer. So I don't know if I can point to anything in a DHSC document, public document, before then, but it was definitely considered right from the start of deployment.

Q. INQ000256951 is, I think, a Public Health England report which you may have commissioned but certainly it came to you and it was actually published right at the end of December --

A. December, yes.

Q. -- 2020, so on the cusp of January. If we could just have a quick look at page 10, paragraphs 2, 3 and 5,

we'll see that it was well known to the department that there were very, very real difficulties with the data systems surrounding the identification of inclusion health groups, persons who had protected characteristics, certain ethnic minority groups, in particular Gypsy, Roma or Traveller communities, or being a migrant or refugee, because, bluntly, as this makes plain, data on certain health groups and protected characteristic groups is variably collected. There's very little data in GP systems relating to the Gypsy, Roma or Traveller communities or homeless people or refugees, and there's no easy central data system which collates information on everybody.

Just at a very high level, the department was obviously aware of the difficulties, therefore, of trying to find out the lie of the land.

A. Yes.

Q. Over the course of the six months, the first six months in 2021, as the vaccine was being delivered, was it actually in any way possible to get on top of these data problems? Were they too embedded, too complex, just too difficult to resolve, so that actually, even by the end of the prioritisation process, nobody really knew how many people were in these communities and how best they could be identified?

A. So, as a number of witnesses have set out, the situation before a pandemic is likely to be the one that you're in in the pandemic, and, you know, for groups that were not registered with a GP, there are a range of things the department did, none of them by themselves make -- would mean that everyone was counted or included, but -- for example, you didn't -- being clear that you didn't have to be registered with a GP to receive a first dose, to encourage registration. For example, the homeless at this time I think were in emergency accommodation, so being able to -- that was -- we were able to -- or local immunisation teams were able to reach those probably more easily than at some other time. So for some groups it might be easier, for others it might be harder, but the advice that -- and this kind of report would also go to JCVI on the types of things to consider, the types of things that local services could do. As I say, none of them were a kind of one thing you could do to reach all of these people but a range of things were necessary, so that we could be as clear as possible that everyone was eligible for a vaccination.

Q. It's obvious, Ms Swinson, that much was done by way of, for example, using local trusted figures?

A. Yes.

Q. Reaching out through the press and social media, setting

up the Community Champions scheme -- I think your department funded it to the tune of about £25 million in January 2021 -- in order to try to improve or increase take-up. But the appearance is that there were a number of, I suppose, peripatetic or discrete or separate methods used?

A. Yes.

Q. But none of them were really very effective in terms of increasing trust, reducing distrust, and getting the message out there in a way that made people want to take up the offer of a vaccination.

The problems with our data systems, with our somewhat fragmented society, were too great for the government to be able to overcome in those six months of getting vaccinations out there. Is that a fair summary?

A. I think that the -- the approach -- there was no -- you're right, there was no one way to say: this is the way to reach all of these groups. I think there's a number of things, like the Community Champions -- you know, there was a number of different schemes or approaches that would each make a little bit of difference that you had to add up in order to make the biggest difference over the course of the year. The approach overall, as I think set out in the uptake plan, is based on the WHO evidence that you need to address

confidence, and actually, the -- we did very -- there was a lot of data, there were surveys on the reasons people might not -- or the barriers to uptake, that you need to address: confidence; you need to address convenience, so there were very many different routes to getting a Covid vaccine than normal vaccines; and you need to address complacency, whether people think that they need the vaccine.

And you need to do action on all three of those in order to drive up the rates as far as possible.

Q. And they're all very difficult issues --

A. They're difficult things to do.

Q. And it's a very complex sphere.

There was in England a vaccines equality committee, there was an equity committee in Wales.

A. Yes.

Q. There was also an equalities committee within the vaccines directorate in Scotland.

Did the DHSC have any sort of advisory committee, comprising members of the ethnic minorities or disabled people's groups or GRT or migrant or homeless representatives, who could say to you, "Look, this is our community, we know how best you can go about this"? Was there any sort of structure or advisory committee that was set up by you that would have helped you?

A. You refer to the NHS England equalities committee, we didn't set up a separate committee but there were DHSC members of that committee, and both through the daily meetings that Nikki Kanani and others came to, was often -- I mean, uptake was a regular -- and the quality of the data and the speed of the data we had about rollout was incomparably better to previous --

Q. What had come before.

A. -- rollouts so that you could -- it doesn't answer the question entirely or the issue entirely, but you could say which are the groups, which are the regions, which are the towns, even down to ward level, where you could ask, or NHS England could ask their local communities and directors of public health to focus.

Q. But at the top level --

A. Yes.

Q. -- the NHS's vaccines equality committee had, for example, no representative from disabled people's groups or organisations, and not every sectorial group or, to use the terrible terminology, the health inclusion groups, were represented on that committee, were they?

A. I don't have a full list but I'm sure you're correct.

Q. Probably not.

A. Yeah.

MR KEITH: My Lady, we won't finish before lunch, I'm

afraid, but -- I've used this phrase before -- we are in the final furlong. Could you consider rising for lunch and we'll conclude this witness shortly after lunch.

LADY HALLETT: No more final furlongs, Mr Keith.

I'm sorry, we had hoped to finish you before lunch, Ms Swinson, and I appreciate the next witness is also from Cabinet Office, so we seem to be denuding Cabinet Office today, but we will finish you quite shortly after lunch, I hope. And I will now break and come back at 2.00, please.

(1.02 pm)

(The Short Adjournment)

(2.00 pm)

LADY HALLETT: Mr Keith.

MR KEITH: Ms Swinson, may we move on to a new topic, that of mis- and disinformation, and have up INQ000502085.

This is a recommendation, or a submission -- if we go to page 1 -- to the permanent secretary, Secretary of State --

A. The parliamentary secretary. They're --

Q. Parliamentary secretary, sorry. Parliamentary secretary and Secretary of State, concerning planned cross-government communications on vaccination, including work being undertaken to enhance vaccine confidence and tackle misinformation.

In general terms, was the issue of tackling dis- and misinformation something that was exclusively for the DHSC, or was this a cross-government issue and included Cabinet Office, DHSC and its Counter Disinformation Unit, the NHS no doubt, PHE, and perhaps other bodies?

A. Yes, it was. As the government lead, it was the Department of Culture, Media and Sport, and the Cabinet Office led the communications hub and all those you mentioned would have been involved in some way.

Q. If we go to page 2 we can see obvious references to research showing quite considerable levels of concern about levels of trust, distrust, vaccine hesitancy. And at paragraph 6, this:

"To alleviate concerns, information on how COVID-19 vaccines are deployed and tested, including their safety and efficacy, must be communicated clearly to the public. It is crucial to understand and address factors that may affect COVID-19 vaccine acceptability in ethnic minority and lower-income groups."

So the starting point is the government, although this is only a DHSC document, could not have been aware of -- of the need to deal with misinformation and disinformation and particularly the related issue of trust and distrust, and the degree to which particular sectorial groups were being prevented from taking up

vaccination or were being put off it.

There's a reference further down the page to the need for further research, for surveys, to understand motivations and barriers.

And over the page, in fact page 5, please, paragraphs 13 to 17.

Page 5, paragraphs 13 to 17, the submission says this:

"13. Research has shown that rebutting each individual narrative is not as effective as ensuring that individuals have access to the best quality information ...

"14. Most individuals that share misinformation are well-meaning ..."

If you attack them, there's a risk of alienation.

So the position appears to have been reached by the government generically that the best way to deal with high and increasing levels of mistrust and to deal with dis- and misinformation, is not to try to engage with it specifically on each specific point or myth or trope or observation that's being made in the public domain but just to keep on plugging the corporate line, if you like, try to get out there and repeat facts and figures and the objective reality of what you're trying to say.

Do you think that was effective as an approach,

bearing in mind that all the evidence now suggests that levels of distrust are higher than ever, levels of vaccine hesitancy are higher than ever, and that trust in government and the NHS in particular appears to have dropped.

A. So, based on the evidence and the research we had, misinformation, I think we did need to address head on people's concerns. They were related to the safety of the vaccine, so it was important that we proactively responded to that, whether certain groups were at risk, and concern about side effects, for example. So we put that in the kind of misinformation camp.

I think on disinformation -- and as this set out, largely done for good reasons and questioning -- it's a very much smaller percentage of people who are proactively putting out disinformation. I think on that we took the approach that you said not to engage in a --

Q. Turf war?

A. -- something that was -- that had been set out, so that's the approach that we took. There are much smaller rates of disinformation, actually, in the UK than in quite a lot of other countries, but as you say, trust in the vaccine programme was related to the position before the pandemic and now about overall trust in government.

Q. Realistically was there much that could be done about that? You could keep on getting the facts and figures, the position about safety --

A. Yes.

Q. -- about side effects, about the opportunities for delivery, acceptance of vaccines, out there, but is there a step or a limit to what you can do and in practical terms, did you reach that point?

A. So I think it varied according to groups. So the data would show, for example, I think in the Bangladeshi population there was a big increase in confidence in trust, whereas for some other groups, that didn't improve as much overall. In fact, at the generic level, 2020 compared to 2021, positive sentiment went up to 96% on the vaccine. Obviously, the generic figures hide a myriad of different groups and reasons, some of which were effectively addressed and some of which weren't.

Q. Do you think more progress would have been made, do you think the outcome would have been better, if there'd been more use of local figures, community champions, trusted figures, that just the governmental back had been put further into trying to use representatives of each particular community better and appeal through them to their communities?

A. Yes, that is definitely again what the research shows,

that for communities where trust in government is low, it shouldn't be government giving the message. So it's exactly community champions working in local areas, I think quite a lot was done on that, maybe it could have been started a bit earlier, the community champions campaign that you talked about, that was the approach in order to obviously do some things nationally, but local communities, local religious groups, local voluntary groups, to use them, where they were happy to take that message into their communities as a more trusted voice.

Q. So more could have been done at the micro level in terms of appealing through local and community-trusted figures to various sectors, cohorts and communities?

A. I'm sure more could have always -- could always be done, and it's an issue now with local communities for take-up of other vaccine campaigns.

Q. Now, of course, to some extent "sow and ye shall reap". We heard expert evidence yesterday about the increased levels of distrust and hesitancy, and there's a knock-on effect, of course.

One -- another angle to this, another aspect of it is the policy of vaccination as a condition of deployment because the evidence appears to show there was a considerable backlash, both in the care sector where the first policy was actually introduced, and also

in the wider healthcare community, as a result of the second proposal, which never came to pass, but the consultation process by which it was going to be introduced in a wider sense.

If we just have a look at INQ000497213, we can see that in January 2022, so about a month and a half or just over a month before the plug was pulled in relation to the expansion of the VCOD policy to the wider healthcare sector, the Secretary of State and Minister for Care and Mental Health, was that Helen Whately? I forget.

A. At that time, yes, pretty sure.

Q. You're asked to note the most recent public health evidence on vaccine effectiveness in relation to VCOD, to note the emerging evidence of vaccine effectiveness against Omicron, and the implication on the VCOD policy.

If we look at pages 3 to 4, paragraphs 20 to 32, you'll see that the thrust of this submission was that in terms of deploying a VCOD policy to the wider care sector and to frontline healthcare workers, the benefit, that is to say the prospect of increasing vaccination rates, appear to be less clear because of course the transmission was ending -- Omicron was making some vaccines less effective, and it was going to be a great deal harder to push rates up even further than they were

already. And the demerit, the downside of the policy, became clear that from the first VCOD policy there'd been a considerable backlash, had there not?

A. [No audible answer]

Q. So was it your department's position in the end, in fact I think on 1 March, that it ultimately wasn't worth the candle?

A. So I think what happened through the Omicron wave is that the evidence changed on whether the -- to what extent the vaccine protected the individual against transmission and in addition to severe disease, and the policy case for introducing this policy was that it would affect transmission to those at risk. Obviously, that was a controversial thing at the time and different things were weighed up but that was the policy, the rationale.

Q. Sure.

A. When it became clear through the research on Omicron that the vaccines were not nearly as effective on transmission, that policy case was no longer -- no longer held, and so it was both withdrawn in the care home sector and not brought into force for all other health and care settings.

Q. It became apparent to the DHSC also, didn't it, that as a result of the first policy, the care home worker

policy and the imposition of VCOD on them, a very large number of people had left the sector? People had walked away because they didn't want to be vaccinated. And you were also aware by this time of the considerable degree of backlash. People took the view that it was a matter for their individual decision as to whether or not they should be vaccinated, and this appears, the policy appears to have led to an increase in distrust and hesitancy.

But hindsight is a wonderful thing. Would you, next time round, go straight away, as you did during the Covid pandemic, for VCOD in relation to care home workers, if that was the most vulnerable area and the area most affected by a pandemic?

A. Yes. I mean, it was a political decision to weigh those things up, and for the personal freedoms against the protection of those most vulnerable. That debate would happen again, depending where politically the ministers took those -- that choice. I think that it was clear when it was introduced, and through the public consultation, that not everyone supported the policy, but ministers and, indeed, Parliament in agreeing the regulations, put that in place.

In terms of care home workers, there are a range of, where -- anecdotally and in survey evidence, I think, it

was a reason given for leaving the sector. It did drive rates up to over 90% as it was a legal requirement but it was also, in choosing to leave that sector, there's a number of reasons -- on pay, it was also when the economy was opening up again, so there's a lot of movement between social care, hospitality, retail, so there was a whole range of reasons of which this -- it's very hard to disentangle.

Q. Very. And of course, the devolved administrations didn't pursue VCOD, none of them did. England was the only country that did in relation to that first policy.

A. Care homes.

Q. Care homes. And their rates of uptake were not significantly lower than England's. So it's very hard to say, at the end of the day, whether or not it worked and whether or not we've created a beast for the future in terms of distrust and hesitancy and so on.

Would one way of trying to find or fight our way through that particular thicket be to understand better, firstly, how many people did leave the sector as a result of the policy, and, secondly, to what degree does a policy such as mandatory vaccination harm us in the long run in terms of willingness to take a vaccine?

A. Yeah, I mean, I'm not sure whether it's an answerable research question in retrospect but if that were

possible that would be obviously very interesting. There's evidence on different countries, both for vaccination for flu, for other things, that WHO also brings together.

It's a mix of factors. I think the professional expectation on healthcare workers, and indeed on care workers, we also see through the annual flu campaigns, and rates are not as high in those groups as they are for the others at risk.

Q. The Vaccine Damage Payment Scheme next.

A. Yes.

Q. The Inquiry is obviously well aware that the payment scheme is not a compensation scheme.

A. Correct.

Q. It's also something that has a statutory foundation, so it's a matter for Parliament, and also it's something on which -- it requires intense ministerial oversight. So ultimately, questions on the remit and the scope of the scheme must be for ministers, because it involves the payment of public monies.

Your statement makes plain that obviously, with the arrival of Covid, Covid-19 as a trigger disease for the severe disablement, which must established, was added by statutory instrument. The £120,000 payment, not, I emphasise, a compensatory payment, but a flat rate

payment, was introduced in July 2007.

A. Yes.

Q. And with the onset of Covid and with the obvious explosion in applications, the body responsible for dealing with these applications, the NHS Business --

A. Services Authority.

Q. Business Services Authority, thank you, increased its membership. I think it has about 80 or more now members of staff now working on it.

The documentation which your department has provided -- let's have a look at INQ000411744 -- dated June 2022, makes plain that your colleagues and ministers considered -- page 2 -- changes to the scheme. There was a proposal, perhaps, to increase the £120,000 flat payment, which, is this right: if a claimant establishes a 60% disablement, and also that the disablement is causally the result of the vaccine, and obviously the Covid vaccine is a prescribed vaccine --

A. Yes.

Q. -- they get the lump sum of 120,000?

A. That's correct.

Q. There isn't a sliding scale?

A. That's correct.

Q. There was a debate about lifting that amount because it had last been uprated in 2007, and there was a debate

also about actually sliding scales in terms of the disablement which had to be established, the degree of disablement, in order to receive a payment.

There was obviously a fair bit of thought given into whether or not the scheme should be changed, bearing in mind that if it was changed, you would then have to backdate -- you'd have to top up any claims which had already been made.

But what happened? We see very little in the paperwork about the outcome of this consultation process, internal consultation process. There weren't any changes made, it would seem, to the rate or the threshold, or the 60% disablement categorisation. Nothing happened. Is that the sum of it?

A. Certainly in this time period, yes, advised the Secretary of State on the current position and the options. As you've said, they would be matters for ministers to ask to take forward. I know there has been a lot of focus on improving the efficiency of the scheme so that those who have applied get a result, and so there's been focus on that, but the ministers haven't taken a decision on any of those points, as far as I'm aware.

Q. Was a decision taken not to pursue the recommended policy options identified at box 3, (c)(i) and (ii), or

is it that no decision has in fact been made at all?

A. Looking at the date, I mean, obviously there have been a different number of different secretaries of state, and I think this was just before -- whilst Sir Sajid Javid was still in post, and he resigned shortly afterwards, so I don't know if -- I'm sure you would have had the paper of any response to this submission, but there hasn't been a response asking the department to implement any of those potential changes.

Q. But we haven't seen a document one way or the other as to whether or not a decision was made, or, if it was made, as it must have been, if it was made, to decline the recommendation. But the upshot is the same: there were no changes made to the scheme, were there, in 2022, despite the explosion in the number of applications. And of course, as you were well aware, very real issues being raised with the department about: quantum, the amount; the speed with which applications were dealt with; the causation threshold; and the issue of graduated payments, if at all.

I don't want to ask you your views on them because it's a departmental policy issue, and it will be for my Lady to determine what, if anything, should be done about the scheme, and of course for Parliament to take a view on it in due course.

But --

A. Yes, the scheme is still operating in the statutory way that you set out with -- on those three bases. There have been no changes.

Q. So despite these very obvious problems which were being brought to your attention, the scheme has not been altered in any shape or form since, in fact, the raising of the threshold to £120,000 in 2007?

A. That's the factual position, yes.

Q. Thank you.

Two final topics, please. Just to go back to the subject of clinical trials, in particular phase II trials for therapeutics, Ms Swinson.

I asked you some questions about the degree of management and co-ordination concerning the phase II trial process for therapeutics, and the Inquiry is aware of the ACCORD process, the evidence in writing from Professor Sir John Bell, Professor Sir Jonathan Van-Tam, and Professor Farrar about what appeared to them to be quite a high level of dysfunctionality and lack of good planning in terms of trying to bring some order to the proliferation of phase II trials. There were a lot of them, there were different funders, they had different numbers of recruits, of participation.

And Charlotte Deane, from the UKRI, has put in her

statement for the Inquiry this:

[As read] "The main lesson to learn is that in the case of a national emergency the UK should have access to a national platform that can deliver integrated, coordinated and comprehensive [that this say covering phase I to III clinical trials] so that there is a UK-wide structure that can select potential interventions, direct resources and coordinate to ensure rapid approvals and trial set-up."

Would you agree?

A. Greater co-ordination for the clinical trials, I do agree on. I don't know much detail about the ACCORD platform, though I've read the statement you refer to. And I know that the technical report from the UK CMO and others points to greater success in phases III and IV than I and II.

Q. Yes.

A. So I would agree with that. I would just say in terms of the platform trials, of which RECOVERY is the most well known, the way that those were set up, recruited to, and the impact that those trials had were truly world-leading, saved a million lives, the first output on dexamethasone, in June 2020. So there were a range of trials and as also the technical report sets out, having them adequately, having enough people in the

trial so they can read out and have an impact is obviously very important. I think the ones you're referring to were ones where -- or the concerns were that they were never adequately recruited so that they could read out and make a clear read out on whether the things they were testing were effective or not.

Q. You'd make, if I may observe, a very fine politician. There's a reference there to dexamethasone, and there's no doubt the RECOVERY trial had a number of groundbreaking results, including dexamethasone, but you were aware, and we've got evidence from Lord Sharma on this, that the advisory group that he had advising him on therapeutic, in particular phase II trials, corporately held its head in its hands at some of the confusion and the lack of co-ordination around about the clinical trial process.

Would you agree that it was plain that a higher degree of co-ordination and management was required?

A. As we're talking about therapeutics, I wanted to point to the one bit of UK -- I mean, world-leading research. There were a range of platforms I don't know well enough --

Q. All right.

A. -- but there were certainly some that worked very effectively. I've seen the concerns about ACCORD which

were led out of UK Research and Investment and BEIS, and I have no reason to doubt them, and that better co-ordination would always be a good thing.

Q. Because the Therapeutics Taskforce and the therapeutic research and development was exclusively, thanks to your ministers, a DHSC enterprise, as opposed to the Vaccine Taskforce, which was BEIS?

A. Yes, I mean, the funding, so there's the National Institute for Health Research --

Q. Yes.

A. -- which is a billion pounds, roughly, from the Department of Health. There's very substantial funding through BEIS for trials through the UK Research and Investment, and the medical research councils that are funded through that, which are funded through BEIS.

Q. Yes.

The Antivirals & Therapeutics Taskforce, in its recommendations of November 2022 on the topic of antivirals --

A. Yes.

Q. -- proposed the building of a library of prototype antivirals that could be then used swiftly or pushed swiftly through the phase II and III clinical trial process on the onset of a novel pathogen. You must have been aware of that recommendation in your position at

the DHSC. Is that something that you would support?

A. Yes, there are people much better qualified technically about what that would mean in practice, but clearly, the next pandemic will not be the same as this one, having a range of potential, on both the vaccines and therapeutics size, antivirals would be a very sensible thing. That is both about getting things into phase I trials but also having -- identifying potential viruses of pandemic potential, and then having research options on the page vaccines and therapeutics of which antivirals would be a part.

Q. And finally on this topic, we've seen reference in the Rule 9 statements to a body called the Advanced Research and Invention Agency. Can you just help us, is that a DHSC-supervised body, do you know, or something different? Or --

A. Not that I'm aware.

Q. I know acronyms in government are much beloved.

A. It's not one that I know.

Q. Is it an arm's length body? Is it an EA? What is it?

A. It's definitely not an EA -- (overspeaking) -- arm's length body.

Q. All right. Evusheld, finally.

A. Yes.

Q. There are two aspects to Evusheld. The first was the

decision not to make an advance purchase or not to pursue an advance purchase, and the evidence makes it plain that Professor Sir Chris Whitty wrote to the Vaccine Taskforce, copied to the DHSC, that he couldn't recommend the buying of a large amount in advance of the Evusheld therapeutic to be used prophylactically.

That decision -- and I must make plain that Sir Chris Whitty's recommendation refers to a number of reasons why the landscape has changed, why there might not be a purpose to it or a sufficient purpose to it, and so on, but the decision has been roundly criticised by, in particular, Dame Kate Bingham, by Clive Dix, and numbers of other people, in particular the immunosuppressed to whom that prophylactic could have come as a great source of help. Was the DHSC aware, when the decision was made, that it left the immunosuppressed, in particular, very exposed in terms of the absence of that particular therapeutic remedy?

A. So the recommendations need to be on the basis of whether such a treatment would be effective. The DHSC was definitely aware that -- or looking for a range of treatments right across the disease path, and the immunosuppressed and those who couldn't take a vaccine were a really important group. They still -- however, the evidence base on whether a treatment would, first,

be authorised by MHRA and deployable, are things that need to be taken into account and both at that point and the subsequent year, the clinical advice from RAPID C-19 that we talked about earlier, to the CMO and then to the ministers, is that there was insufficient evidence for that -- for it to support procurement.

Q. But in the case of vaccines, massive at-risk advance purchasing was made in the complete absence of any real clinical data to suggest they would work, indeed in advance of the completion of clinical trials?

A. Yes.

Q. And later, when it came to the decision whether or not to authorise the purchase and deployment of Evusheld in 2022 as a treatment, and that's the process, the RAPID C-19 process that you spoke of --

A. Yes.

Q. -- the decision by RAPID C-19 not to go ahead with Evusheld wasn't based on clinical data so much as a view being taken on how useful it would be, given the emergence of Omicron in particular. So Evusheld didn't receive the same fair crack of the whip as the vaccines, all the vaccines had?

A. First of all, RAPID C-19 would definitely have looked at the clinical data. As we set out in 2021, the context was different, given we had such effective vaccines.

information into translated languages and at what time those measures would be.

A. I'm afraid I don't have detail about exactly what materials, but both Public Health England, or UKHSA, depending on the timescale here, and NHS England, I know, in normal business, would make available information in different languages.

It's obviously important for accessibility, as I've set out, but you would need to put that to Public Health England or NHS England.

Q. So you can't help me with whether those measures were taken -- in respect of translations was sufficient and successful, because that's something you can't speak to?

A. Yes, that's for other organisations.

MS NAIK: Okay. Okay, well, I think we will then have to put that elsewhere. Thank you.

LADY HALLETT: Thank you, Ms Naik.

Ms Beattie, who is also just in front.

Questions from MS BEATTIE

MS BEATTIE: Thank you, Ms Swinson. I ask questions on behalf of disabilities organisations. The department published the Vaccines Delivery Plan on 11 January 2021 which Mr Keith has already referred to, and that referred to directly employed personal assistants forming part of the social care workforce.

There certainly were advance purchase agreements in place for some therapeutics, but you're right that the advice was not to put that in place for this treatment, and in the event, those -- our advance purchase agreements were, I think, always on the basis of getting to a conditional marketing authorisation and that happened for Evusheld in the spring of 2022.

MR KEITH: Thank you very much.

LADY HALLETT: Thank you, Mr Keith.

Ms Naik, I think you've got some questions, thank you.

Can you see that way?

THE WITNESS: Thank you.

Questions from MS NAIK KC

MS NAIK: Thank you very much, my Lady. Thank you.

Ms Swinson, I represent the Migrant Primary Care Access Group and I just wanted to ask you a couple of questions based on what you said in your witness statement at paragraph 129. You obviously don't have to look that up but it's about translation.

What you said there was that:

"Translation was a priority to reach those whose first language is not English."

I just wanted to know if you could elaborate on what measures were taken to disseminate public health

Could we bring that up please. It's INQ000411678.

We're at page 42 of the document. If we could please highlight the third paragraph towards the end, the final sentence there says that:

"... it [was] vital [to] identify and reach directly employed personal assistants ... as part of our efforts to ensure full coverage of the priority 2 cohort."

Just to remind everyone, that was the cohort that included frontline health and social care workers; is that right?

A. That's correct.

Q. Disabled People's Organisations are aware of concerns raised by disabled people who employ personal assistants about a lack of clarity on how to secure vaccines for personal assistants and when their staff could be vaccinated, and that they were bounced between GP, clinical commissioning group and council with no organisation taking responsibility.

What, if any, guidance did the department provide to disabled people and personal assistants to facilitate vaccine access and uptake of the vaccine by personal assistants who, for disabled people, are part of the frontline social care workforce?

A. They are, and as set out here -- I think the department made clear they were part of that cohort. In terms of

specific guidance for them on how to access vaccines, I think that would have been through the local NHS, and also as set out in the Green Book, it might have said more there.

Q. Well, I think the Green Book doesn't mention personal assistants at all by name.

A. Okay.

Q. Are you saying there was local NHS guidance which was directed to disabled people and personal assistants that covered this matter?

A. I'm saying that this sets out the cohort. It was an NHS operational issue for how to invite the people in those cohorts under this, and for each cohort to come forward for their vaccination.

Q. And so is your answer that there was nothing from the department itself that covered this?

A. I'm not aware of any specific guidance on personal assistants in priority 2 cohort, no.

Q. And further to that, did the department undertake any consultation with disabled people and disabilities organisations about facilitating access by personal assistants to vaccination?

A. These issues would have been covered on JCVI and part of the PSED -- the equality impact assessment, but I'm not aware of anything in further detail, and it would have

been an operational matter for NHS England.

Q. Just to be clear, do either that advice or a PSED, does that include consultation actually with disabled people and DPO?

A. I'm not aware of consultation on the JCVI guidance in the way you set the out, no.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Beattie.

I think that completes the questions for you, Ms Swinson. I'm really grateful, I know you've helped me before. I don't know whether I'm going to be asking you to help me again, and I do understand the burden that will be placed upon your old department, and I suspect also your current department, so thank you very much for the help you've given to date.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: I hope we haven't kept you hanging around too long, Ms Little.

THE WITNESS: Not at all.

MS STEPHENSON: My Lady, the next witness is Catherine Little.

MS CATHERINE LITTLE (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Congratulations on your new role since we

last met.

THE WITNESS: Thank you very much.

MS STEPHENSON: Please could you say your full name.

A. Catherine Little.

Q. Thank you for attending to assist the Inquiry today.

Could I ask you, as you may have heard with other witnesses, just to keep your voice nice and loud and to speak slowly.

You have produced a witness statement, INQ000474557, dated 21 October 2024. It runs to 80 pages and annexes and 220 exhibits. It is signed by you.

Can you confirm that you have had the opportunity to read it recently and that it is true to the best of your knowledge.

A. Yes.

Q. Thank you. I'm going to start with some background matters first.

A. Upfront, if I may, I'd quite like just to personally express my sincere sorrow for the impact that the pandemic has had on so many lives, and also just to assure the Inquiry how prominent the risk of life was in all of the considerations that we undertook in the Treasury.

Q. Thank you.

Your professional background. After a career in

professional services you joined the Civil Service in 2013, went on to hold senior roles in the Ministry of Justice and Defence, and then joined the Treasury in 2020 as director of public spending. Is that correct?

A. The Director General of Public Spending, I apologise.

Q. I'm so sorry, I thought that was what I had said, Director General of Public Spending --

A. Apologies for correcting you.

Q. -- thank you. Can you explain what roles you have taken since that time?

A. Yes. So in October 2022 I became the Second Permanent Secretary to the Treasury, with responsibility for public spending and international matters. And then in April 2024 I became the Permanent Secretary of the Cabinet Office and the Chief Operating Officer for the Civil Service.

Q. You mention some key figures in your statement. I'm sure it's news to no one but, just to remind ourselves, Rishi Sunak was the Chancellor for the entirety of the period that we're going to be discussing today, and the other key figures you mention in your statement are Steve Barclay MP and Simon Clarke who successively held the roles of Chief Secretary to the Treasury; is that correct?

A. Yes.

Q. Thank you. Within the Treasury, is it right that there was a dedicated team for Covid-19 vaccines from March 2020?
A. Yes, that's correct.
Q. And at all times, that Covid-19 vaccines team worked closely with the Department of Health and Social Care and the Department for Business, Energy and Industrial Strategy, particularly closely with those two departments?
A. Yes.
Q. We can't endeavour here, of course, to unpick the complex web, that you set out in your statement, of decision making, of requests for funding, and of approvals processes and the sophisticated thought that went into that and the negotiations of contract. So I just want to take you through some of the headlines about the approach that the Treasury took to vaccines and therapeutics during the period that Module 4 is concerned with.

The first topic I'm going to ask you about is vaccine development, procurement and manufacture. You explain in your statement, and I'm just going to ask you to assist us a little here with the general approach, ie, the approach to spending approval not in a situation as the department was in during Covid.

scientific approaches, each with different manufacturing requirements ..."

Paragraph 3, that recognises that:

"By pooling resources and risk internationally ... we can increase the global chances of success ..."

But the scale of investment required, it recognises, is going to be substantial, there's no guarantee of success.

If we could also turn, please, to page 7 of that document. At that point, reminding ourselves it's 7 April, there were three candidate vaccines which will have different manufacturing needs. We see there the vaccine being developed at Imperial College London, and then there's mention of the vaccine being developed in Oxford in (b), and mention of Moderna at (c). And of course we know now that whilst one vaccine at Imperial College London didn't make it to approval stage, (b) and (c) are what would go on to become vaccines that were used in the UK.
A. **(Witness nodded)**.
Q. Thank you, we can take that document down.

Whilst we know that now, is it right to say that the vaccines programme was extremely unusual at the time in terms of its uncertainty, and unusual in the Treasury approach to spending control?

Is it right that the principles that you follow, as set out in your statement, are regularity, propriety, value for money, and feasibility, but that that general framework was applied with a great deal of flexibility when it came to vaccines and therapeutics spending approval?
A. Yes, that's correct. And to expand, if I may, the principles of the managing public money framework were consistent throughout. We didn't change the framework in any way but we did apply one, a much higher level of risk taking and secondly, we adapted and flexed it in a very pragmatic way to suit the circumstances that we were dealing with.
Q. If we might turn to some of those specific approaches, funding the vaccine programme, and if we could have on the screen INQ000421318, please.

This is Treasury officials' advice to the Chancellor, advice that was accepted, regarding the Covid-19 vaccine development strategy dated 7 April 2020.

If we could turn, please, to page 2, at paragraphs 2 to 3, perhaps to set out some of the context in which your department was working:

"Vaccine development is high risk and poses significant technical and time challenges ... several

A. That is right. It was highly unusual, but our overwhelming advice at the time was that it was right to take a much higher risk approach, because the overwhelming case for the benefits, about to public health and to the economy were so significant it outweighed any of the initial risks. So we advised the Chancellor to invest in all vaccines that proved to be promising and to explore every single opportunity at this stage.
Q. You describe that as a three-stage approach in your statement. The first is a generous commitment envelope. Can you translate for us, what does that mean, a generous commitment envelope?
A. Normally, what we would do in public spending is to provide a precise amount of money for a very precise outcome that the government is trying to achieve. In this instance we took the view that given we really didn't know what it would ultimately cost or over what time frame, that we should give the maximum amount of flexibility and provide a funding envelope over a multi-year period that was significant enough to allow the Vaccine Taskforce to operate with a significant amount of freedom and pragmatism. That is absolutely unheard of outside of a spending review or in normal spending practice.

LADY HALLETT: As I say, it must have gone against all the instincts of you and your colleagues?
A. It did, and I think it's fair to say I expected to come into the Treasury to control public spending with an iron fist and I ended up spending a huge amount of money and changing our risk appetite radically almost overnight.
MS STEPHENSON: And that resulted, didn't it, in a three-year period being covered by the envelope, and by funding outside of the usual spending review period, I think as you have described.

Second, then, the Treasury sought explicit ministerial consent in respect of indemnities. Is it right that ministerial consent is required for all government contracts involving indemnification because of the liabilities to the Exchequer?
A. Yes, and it's actually important that approvals are sought from Parliament, because the contingent liabilities produced by these sorts of indemnities are so novel and contentious and potentially very significant to public finance.
Q. I'm not going to ask you to go into the detail of any individual contracts or negotiations, or the specific terms, indeed, of indemnity arrangements at any point in your evidence. But is it right to summarise it in this

way: that indemnities were agreed by the Treasury for vaccine developers in which the Exchequer bore a much higher share of the risk than would normally be the case, in order to be successful, or in order for the VTF to be successful in negotiations with developers to secure contracts?
A. Yes, that's correct, and we took the view that we had to take exceptional risk in order to secure those commercial arrangements quickly and ahead of global demand in the space.
Q. Do you think, as far as you're able to know, do you think it is likely that had the UK taken a different approach by not agreeing to such indemnities it would have been able to secure the vaccine supply contracts that it did?
A. I think it's highly unlikely that we would have been able to secure those contracts given the pace of demand on a global level, and pace and risk-taking were key in the success of the commercial arrangements.
Q. The third and final element of the framework that you set out in your statement was increasing the limit to which the Treasury delegated authority to BEIS to spend without specific prior approval. Can you just explain a little about that and why it was different?
A. In normal times, every department has a risk-based

delegated approval level that's set every year by the Treasury. For BEIS, that was set previously at £70 million pounds. We increased that to £150 million, which was a bit of a judgement call as to what the right level was, but we felt that having seen some of the activity that was under way, that was a level that would allow them to pragmatically sign up to further expenditure without any further delay by coming to us.
Q. So pausing there and taking stock of that framework which you've helpfully described for us in overview, are there lessons that can be learned in respect of future pandemics and preparedness from the flexible approach adopted in the Covid vaccination development programme?
A. Yes, and we talked about two of them. The third one that I would add, and I know many witnesses have talked about, is the governance arrangements that we put in place through the ministerial panel. In normal times, spending approvals would go through a multiple sequence-stage process, and in effect we streamlined and collapsed all of that into one decision-making process, and we would certainly repeat that again if we were in the situation.
Q. Just finishing perhaps off that point about the VTF ministerial panel, ordinarily, separate ministerial approval would have been required for each spending

decision by BEIS, the Treasury, and the Cabinet Office. And so you describe that single decision point.

To be clear, it's not that the Treasury lost any of their usual authority, power, final say, whatever we want to term it, in those spending decisions, it's just that you collaborated at that stage. Would that be a correct summary?
A. Yes, that's correct. It's important to emphasise that the Treasury cannot delegate its responsibilities for Treasury consent for novel, contentious or repercussive matters, and that is an important constitutional principle in the role of Parliament and how it delegates its authority to the Treasury.
Q. I want to move on now to the specifics of the Vaccine Taskforce programme business case. Funding for the vaccines programme between March and July 2020 was drawn from a combination of funding sources on a case-by-case basis. Was it considered that it was important to build a more stable base of funding for the VTF, and that they then made a business case for that funding base in the beginning of July 2020?
A. Yes, I think we realised very early on that this process of continually coming back to the Treasury was not going to be an effective way of operating, and that business case was specifically to justify the multi-year funding

envelope.
Q. There are a number of adjustments to that business case, and I'm not going to enter into the complex back-and-forth of that, but just to go to the headlines here, is it right that the final business case went in on 29 July 2020, and that then that -- the sum that was requested, which was 5.23 billion at that stage, was finally settled in September, but that the VTF were notified that that approval was earlier, it was that the official letter, as it were, went out in September?
A. Yes, that's correct. And that's quite normal for us to receive a readout from a minister, in this case the Chief Secretary, to let the department know, and then for us to formalise the conditions of that approval over a slightly slower time. But we're talking about a matter of days.
Q. You were aware that there are some concerns raised by Dame Kate Bingham at the time, about the delay in this process. I don't intend to go through all of those in detail because, of course, the specifics of what was or what was not appropriate in this pandemic may differ next time, depending on the nature of any virus or potential vaccines to combat it, but in terms of the broad lessons we might learn from some of the concerns raised by Dame Kate Bingham at the time, you're aware

that concern was raised about the speed of approvals, that that was raised on 22 July 2020 in a meeting with the Prime Minister. And that essentially the concern was that making a business case with any -- anything approaching certainty about figures was very difficult because, being asked to estimate quantity and cost of vaccines in June or July 2020 when there was no clear idea of what those figures would be was challenging, and that it was rigid and consumed the VTF's time and energy and caused delays.

Do you understand those concerns, and can you explain what the Treasury's response to that was?
A. So I've obviously spoken to Kate and I talked to her at the time about her concerns. I think there's a few things I would say in response. Firstly, the Treasury at this time was often signing off very complex material amounts of public spending, often within 48 hours of us receiving a case. That is an extraordinary thing for us to do, given the scale of public spending and the risks that were involved, and our teams worked around the clock to make sure that frontline services, and in this case, the Vaccine Taskforce, got as much approval as quickly as possible to get resources to where it was needed most.

Throughout the period when we were looking at the

funding envelope, we continued to sign off specific approvals and we signed off £1.3 billion worth of additional specific approvals so that we could continue with the momentum and the pace of the work of the Vaccine Taskforce. I think it is absolutely right and proper that a business case is produced. It's fundamentally the record of how we are looking at decision-making and the risk and benefit to the taxpayer. And I think on the actual use of the Green Book, this sort of view that it's quite a rigid way of undertaking investment appraisal. A few things I'd say, firstly the Green Book has been developed as a best practice and investment appraisal over many decades.
Q. Can I just pause you there, because we have another Green Book in this Inquiry.
A. Oh yes, of course.
Q. Can you just explain what the Green Book is, as you're referring to it?
A. Apologies, yes, there are lots of books. The Green Book from the Treasury perspective is the guidance that sets out how practitioners should undertake government investment appraisal for the public sector. And it is seen globally as one of the most longstanding, mature sets of guidance in this space.

There's lots of myths about the Green Book. So

a number of witnesses have referred to there being a sort of magic benefit-cost ratio or that the templates were very rigid. It's not designed to be a prescriptive approach, it is a toolkit of methodologies, and it fundamentally sets out how you consider quantifying risk and uncertainty when you are dealing with so many unknowns. And I think this is very, very pertinent to the Vaccine Taskforce. That is not unusual in government and the public sector.

So it's important that when we're talking about this sort sum of money, which is nearly a penny on Income Tax, that we are really thinking about the material risk and benefits to society, and I think it's important to take a proportionate approach.

We're not telling departments how to do it; we are giving them guidance.
Q. So are you of the view that there is another, better, perhaps more scientific, less financial model, that might be used in these scenarios that could be more nimble, or is your position that the model that was used was appropriate?
A. I don't agree with the idea that you should have a scientific case. The Green Book sets out quite clearly in its principles that evidence and data should be used throughout, and so my argument would be that

scientific evidence and data should be fundamental to each of the five cases that the Green Book sets out.

And again, it's not designed to be a prescriptive template; it's up to the owner of the decision, and in this case the Vaccine Taskforce, to decide pragmatically what evidence should be included and what level of judgement is applied in the assumptions in the case.

Q. I'm going to move on now to ask about vaccine manufacture and onshoring capabilities and the spending decisions around those.

You explain in your statement it was recognised that from the earliest weeks of the pandemic the UK needed to work urgently to develop domestic vaccine manufacturing capacity.

If we could have a look, perhaps, just to illustrate the point, at INQ000421297.

This is a letter from Matt Hancock MP, the Secretary of State at the time, to the Chief Secretary to the Treasury. A little later than we've been talking about, 18 June 2021. If we see at paragraph 3 there, it's recognised that "the UK is not alone", that there is competition, as it were, out there, and the VTF has been asked to "identify transformational investments which will significantly strengthen the UK's long-term responsiveness to future pandemics".

And if we have a look at, also, page 2, please, at paragraph 2:

"Time is not on our side: not only can some of these investments provide contributions to our vaccine resilience late this year and early next, but the global competition is fierce."

So was it clear throughout the period in which spending decisions were being considered that there was a real urgency over vaccine manufacture?

We can take that down now, thank you.

A. Yes, and I hope you can see that throughout, in all of our advice and in our interactions, the resilience of the UK manufacturing sector for vaccines was a significant priority for the Treasury, and later that year, at SR21, which took place in November, as the correspondence leads to, we invested in a range of different options, including the VMIC, Braintree, the CPI in Darlington, and we also provided some further funding to BEIS to invest in resilience in manufacturing overall.

Q. If we could just talk about some of those specific investments, dealing first with the Vaccine Manufacturing Innovation Centre.

The Inquiry has already heard evidence today about the fact that that was a facility that would hopefully

promote, develop and accelerate new vaccine production, technology and manufacturing. But the project suffered significant issues and delays, to the point where it was no longer commercially viable.

There was significant investment in the Vaccine Manufacturing and Innovation Centre. Could you set that out for us in summary?

A. Yes. So I think the first investment from the government was undertaken in 2017, and you can see a series of further investments over the course of that period leading up to SR21.

SR21, by that point £205.7 million had been invested in VMIC, and at the SR we provide a further £80 million in order to complete the project.

Q. You've exhibited correspondence which explains there are a number of further delays from 2021, it appears associated with construction and delivery. And it became apparent that it wasn't going to be useful within the immediate life of the pandemic, and of course, eventually, in 2022, it was sold. What was the rationale from a Treasury perspective behind that sale?

A. So I think you can see from the correspondence between the chief secretary and George Freeman that we were actually quite concerned about the sale and the potential repercussions for resilience, and we asked

a number of quite searching questions about whether that really was the right option. So we looked at what was being done to address residual vulnerabilities, what the scenarios were for step-in rights and whether we would lose those step-in rights, and what we would actually do. We also asked BEIS to safety out all the other alternative options that they had considered and to look at the impact on other innovation investments that we had previously provided funding for.

And ultimately there's a chain back and forth on all of those questions. Ultimately the chief secretary took the view that we had to rely on the expert views of BEIS and ministers there, but there were several conditions that we put on that sale, with each of those conditions and issues being raised.

Q. Were the funds from the sale, are you able to assist us with whether they were directed back into manufacturing, so as to ensure that that investment was not lost?

A. I'm afraid I don't specifically know the answer to that question.

Q. The decision -- and you may be aware of some of the concerns expressed that the decision to sell was a move in the wrong direction because it lost significant manufacturing capacity, perhaps that is obvious, but also those relationships with vaccine manufacturers that

went along with it. Did the Treasury consider the impact specifically of the relationship loss in its decision making?

A. I don't recall seeing specific evidence of that. But I think -- I can obviously see that that was the case from the information that has been provided by the department. But ultimately, our responsibility in the Treasury is -- was to provide the approval, given it was quite a novel and contentious thing to have done, and especially given the amount of taxpayer money involved. Ultimately it was up to BEIS to provide assurances and to meet the conditions that we put on the sale.

Q. Just touching briefly on two other manufacturing investments which I think you have mentioned, Braintree and the Centre for Process Innovation. Simply to ask, do you know, are you aware of the current status of these sites?

A. Forgive me, I don't. It's beyond the scope of my current responsibilities.

Q. Perhaps the last important point to mention is the Moderna strategic investment. A strategic partnership was agreed with Moderna at the end of 2022. The Inquiry's understanding is that this is a ten-year partnership agreement. How does that partnership assist the UK in strengthening its domestic manufacturing

capabilities?

A. I'm afraid I wasn't directly involved in that strategic partnership other than the oversight of the funding that was provided alongside the deal, so I don't know the detail.

Q. All right, I'm going to turn now to another topic, which is -- somewhat controversial at the time and a matter of importance to a number of Core Participant groups in the Inquiry, and that's the termination of the Valneva contract.

Valneva was one of the manufacturers within, of course, the VTF portfolio, but its contract was terminated ultimately, never rolled out to the public. I don't need to go through with you the fine detail of this, but if we might look at an email, please, of September 2021 and if we could have on screen INQ00512911.

And within page 1, we can already see, this is -- thank you. In fact, could we just zoom out again so I can see -- thank you.

The date on this is 10 September 2021. And it is an email representing the view of the Chief Secretary to the Treasury, Steve Barclay, about the termination of Valneva contract. The beginning of the email -- and if I could zoom back in now, thank you -- explains:

"His view was that, if the clinical advice is that the vaccine doesn't work, then we should terminate with immediately effect in line with the advice."

Now, I appreciate clinical advice is something entirely outside of your remit. There is in the second paragraph a desire to recover costs. And then this, which I'd like to ask you about:

"Finally, he noted that it was surprising that the advice was not being shared with the [Secretary of State] BEIS and Lord Agnew, given they are members of the VTF and the advice notes that 'this is one of the two vaccines scheduled for delivery at significant volumes ...' He noted that this points to an earlier concern that there seems to have been a change of approach to engagement with the ministers and commercial experts within the VTF since the change of leadership."

And he goes on to ask for some follow-up actions to be carried out in respect of that.

Thank you, we can take that down.

So the concern which seems to be expressed here, if we cast our minds back towards the beginning of your evidence, the very effective ministerial panel that you described, that the process for the termination of the Valneva contract had not gone through the panel in that same way. Can you help us with what the Treasury's

understanding at the time was of the position and any concerns around that?

A. Yes. So it's correct that it didn't go through the ministerial panel in the way that decisions of this nature normally would. We were directly approached by the Vaccine Taskforce with a recommendation to cancel the Valneva contract, and as you can see from that correspondence, the minister was quite keen that the principles of the ministerial panel were put into practice for this decision, and in -- I think that's important, given we'd spent £354 million by this point on the Valneva vaccine.

I would note that we were forecast to spend an additional £590 million, and so what isn't in that correspondence directly, but is in other parts of my evidence, is that we also did look at the value for money of that decision.

Q. Did you understand the reason for that process not having been followed?

A. I don't.

Q. And do you know what the outcome was, in terms of that being fixed, or followed subsequently?

A. I recall that the information was shared as the Chief Secretary requested but I don't have any other details of what the follow-up was to that, and that process.

Q. You may be aware that there was some concern, including from Dr Clive Dix, that that decision at the time was misguided because it might do damage to the wider relationship with the pharmaceutical and bioscience industry, given the decision and also the timing of it.

Is that something that the Treasury took into account when it was involved in these discussions?

A. That wasn't within our role and remit, and I can obviously see where Clive is coming from, but that wasn't a particular issue or within the responsibilities of the Treasury.

Q. I'm going to move on now to a different topic, and that's therapeutics and in particular, at first, antivirals.

Ultimately, the UK Government secured over five million courses of antivirals to treat Covid-19 and the Treasury of course approved that funding. But there have been some concerns that there was less of a willingness to invest in development of antivirals versus vaccines. Can you explain, please, what the Treasury's view, if any, was, on what ought to take priority when it came to spending decisions?

A. Yes. So it's important to emphasise that the Treasury always saw a very critical role for antivirals in the response to the pandemic, especially in relation to

clinically vulnerable groups and for those who could not have the vaccine, and I think we stressed that throughout all of our advice, and that's why we signed off an envelope of £621 million at the very start of the taskforce's work.

The two phases that follow, there are different considerations at play. So in August we're approached to review a business case with expenditure up to £11.1 billion over a two-year period. And in effect what the Treasury's advice set out was that there was some benefits to the case, particularly for the public health benefits that I've just alluded to, but also the commercial benefits of getting ahead and attracting the discounts that had been negotiated.

But on the other side you've got a very, very significant risk of a material amount of public spending, £11.1 billion pounds would have been more than we were investing overall in vaccines, and we did have concerns about the clinical information we had available at the time about the effectiveness of antivirals, and at that stage I don't think we'd undertaken peer reviews of the clinical studies that were available to us. So there was a very real risk that we were going to spend material sums of public funding on antivirals that may not ever be used or may not be effective.

I think it's right that we set out that balance of risks and benefits in the advice that we gave to ministers, and ministers ultimately concluded at that stage that they didn't want to increase investment.

In the second phase in December, when a further case is made to the Treasury --

Q. Can I just pause you there just to add some context. But -- please continue once I've done so. But the second phase was in response, was it not, to the Omicron variant, and to a concern that some vaccines might not be as effective against the Omicron variant, and that antiviral investment needed to be increased in order to guard against that?

A. Yes. That's correct.

Q. Okay, please continue. Thank you.

A. I suppose the additional consideration at that stage was one, whether we would be able to deliver the courses in time to respond to the peak of the Omicron variant which was forecast to be in January in 2022. But also the point you've made about vaccine escape risk and to what extent there was evidence that for those who had been vaccinated, this would in any way reduce the rate of hospitalisation for vaccinated people. And that was quite a critical part of the decision making from a value-for-money perspective. And Philip Duffy, my

colleague who led on this, spoke to Jonathan Van-Tam at the time to double-double-check our understanding of this question of vaccine escape risk and effectiveness, and I think what Jonathan says is there's quite material variation in your value-for-money calculation, depending on the range of results that they were seeing at the time.

And the anticipation was that the PANORAMIC trial would conclude in January and so we should continue to invest in order to see the benefits of that trial and hopefully to be able to meet the demands of the Omicron peak. So those were the considerations.

Q. In terms of the business case that was submitted in that second phase after the Omicron variant was of real concern, the business case was submitted by DHSC and it had, if you like, the backing in the sense that it was supported by the department's senior clinical adviser and the Office of the Chief Medical Officer. If their view was that it was advisable to increase funding in antivirals, was it for the Treasury to, if you like, overrule or go behind that by doing its own assessment of whether or not antivirals were something that ought to be invested in?

A. So I don't recognise the characterisation of the Treasury doing its own clinical assessments. The role

of the Treasury is to faithfully represent the view of experts and throughout the pandemic, and in normal times, that is how Treasury sets out impartial, professional and objective advice to ministers.

What is the purview of the Treasury is to set out the trade-offs in public spending. And it's important context that at this point -- I mentioned that, you know, we're quite significantly ahead in vaccine rollout. You can see that the benefits to the economy are starting to take effect, and we've already spent a significant amount of public funding on the vaccines.

At the same time we're being asked to spend even more money on something that hasn't yet been proven to be effective. And so I think it's absolutely right that Treasury ministers are looking at the balance and proportionality of public spending, especially when it is such a significant sum of money.

So at no point does the Treasury attempt to, in any way, take a clinical view. We're trying to balance the proportion of public spending and whether we think it's good value for money.

Q. Right. I'm going to move on now to the final matter I want to ask you about, which is under the heading of lessons learned and recommendations. You have already referred to some of the innovative ways of working that

happened when it came to investment in vaccines and therapeutics. Can you explain to us, what was the good that came out of that part of the department's working which you think would be beneficial to repeat should the UK find itself in the same situation again?

A. We -- so I think there are three really core things. One is the explicit use of risk-based judgements and risk-management techniques in articulating the balance of risk, how you try to quantify uncertainty and benefits when making these sorts of decisions.

I think the fact that we very explicitly upfront said that we are going to take a very high-risk approach, because the benefits are so overwhelming only positive, that means we are fundamentally changing everything we are doing. And I think using that sort of risk appetite framework in a professional way is incredibly important in decision making.

Secondly, we talked about the flexibility of the spending framework, and we've run number of lessons learned on the detail of that, which I won't go into, but I think it shows that you have to use the framework flexibly and in a very fast and agile way, without in any way undermining the important delegations that we are given by Parliament for public expenditure.

And we've talked about the big spending envelopes,

the way in which we did governance, they're all examples of applying that spending framework in a flexible way.

And then the consolidation of governance. I mean, we would have saved many months, I believe, by consolidating into a single ministerial decision point, and I would repeat that immediately. And there are many instances outside of a pandemic where I think there are some valuable lessons to be learned.

Q. And what about things that could have gone better? Have you identified any of those?

A. So I think there are a few things. Firstly, the use of data, and the consistency of data, and I think the chief secretary alludes to this specifically in a number of different ways, but I think making sure that your data is shared, open, consistent. We did very well in lots of different circumstances, but really investing in the quality of data in government is key.

Commercial skills, I think on one hand we did a very good job at moving some of our most talented commercial leaders to the places they were needed most, but the raising of commercial skills across the whole of the Civil Service is an ongoing endeavour and we've made lots of strides but I very much agree with the comments that Kate Bingham has particularly made around STEM and commercial skills. And that happens to be part of my

current role within the Cabinet Office and something I take very seriously.

And then thirdly, embedding the Cabinet Office and Treasury upfront into programmes. I cannot emphasise how important that was. We did it well in the case of vaccines, but to do it consistently I think matters. It means you're developing your understanding of decision making right from the start rather than trying to play catch-up later on in a process.

And then finally, we did some very specific work on how we support accounting officers, and I think there are some quite technical aspects of the way in which we do that, that we've documented some lessons learnt on in the Treasury in particular.

MS STEPHENSON: Thank you. Those are all of my questions.

LADY HALLETT: I don't think there are any Core Participant questions.

MS STEPHENSON: No.

LADY HALLETT: I'm really grateful, Ms Little. Thank you so much. I am sorry we have taken two permanent secretaries away from the Cabinet Office in the same day. I hope we haven't caused the government to come to a close.

Anyway, I also don't know whether I might be asking for your help again. I do have other modules that may

or may not be coming across your desk, so thank you in any event for of the work -- for the help you have given me so far.

THE WITNESS: Thank you, my Lady.

(The witness withdrew)

LADY HALLETT: Very well, 10.30 on Monday? 10.30 on Monday. Thank you, all.

(3.23 pm)

(The hearing adjourned until 10.30 am on Monday 20 January 2025)

I N D E X