Witness Name: Sajid Javid
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UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE

Module 4: Second Witness Statement of the Right Honourable Sir Sajid Javid MP

I, Sir Sajid Javid, MP for Bromsgrove will say as follows: -

INTRODUCTION

1. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 11 January 2024 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a personal statement for my recollection of issues relating to the development of Covid-19 vaccines and the implementation of the vaccine rollout programme in England, Wales, Scotland and Northern Ireland between 30 January 2020 to 28 June 2022. I have also been asked for my recollection in relating to the treatment of Covid-19 through both existing and new medications.

2. This statement covers the period set out above. Where it is necessary to refer to events outside the date range, I will make that clear and explain why I have referred to the event. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that the Department of Health and Social Care (the Department) continues to prepare for their involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be. I shall refer to parts of the corporate witness statement filed on behalf of the Department where

appropriate and necessary. Throughout this statement I rely on the following versions and will refer to them as:

A. 'DHSC Statement A': The sixth Witness Statement of Clara Swinson.

B. 'DHSC Statement B': The seventh Witness Statement of Clara Swinson.

C. 'DHSC Statement C': The eighth Witness Statement of Clara Swinson.

Recollection/Recall

3. I can remember some events which took place during this period but would identify that I have sought to look at contemporaneous material from my private office or from briefings and submissions to examine what decision I made during this period. Much of my recollection of the detail of what happened and when has been obtained from that information, and in particular my official diary, and the notes taken by my private office. As can be imagined, I was undertaking a considerable number of meetings in any one day. I did keep some notes at the time but only in a rough format. I have sought to find such notes as are in my possession and have exhibited them where relevant. I did not keep notes routinely. In drafting this statement, I have also consulted with a special adviser in my private office at the time (Samuel Coates) who was involved in the vast majority of meetings that I attended. I have also sought assistance from the corporate witness statements produced by the Department and have read them as part of my preparation for providing this information.

4. Given the time constraints, the Department has not been able to conduct a full search of all potentially relevant documents but has sought to find relevant documents which highlight the essential issues which this witness statement raises. I have also been unable to go through all the documents that my private office would have received during this period given the number of documents and the length of time that would take. The Private Office of the Secretary of State operates a "triage" system deciding what information I need to see and how and when I see it. The Secretary of State gets sent, and is also copied into, multiple submissions, advice notes and other sources of information daily. I was not necessarily able to read all of it. I did read all submissions directed at me where I had to make a decision.

5. There are many acronyms used in this witness statement. I will explain them where appropriate but note that the corporate witness statement has explained many of them, which I will adopt.

Key decisions, actions and documents

6. The list of key decision makers and overall role of the Secretary of State and those who supported me during my time in office in respect of vaccines and therapeutics are set out in the corporate witness statement of Clara Swinson (Module 4A) paragraph 10 - 14. I have nothing further to add to this.

Vaccines - overview

7. As the Secretary of State, my role was to oversee and make decisions on policy and practice on the commissioning, funding, delivery and roll out, along with a number of other organisations, of the vaccination programme for Covid 19 and on development of therapeutics. The initial procurement, funding and work on vaccines had been all implemented by the time I assumed my role, so I have nothing to add or reflect on those issues.

8. I became Secretary of State on 26 June 2021 until 5 July 2022 **(SJ3/1- INQ000479876**. During that time, the "key" new issues in respect of vaccines and therapeutics included:

   a. The vaccination of those under the age of 18 **(SJ3/2 - INQ000480659).**

   b. The booster campaign of the summer of 2021 **(SJ3/3 - INQ000257044).**

   c. The need for additional "booster" vaccinations from December 2021 onwards to deal with the Omicron wave **(SJ3/4 - INQ000257180)**.

   d. Delivery of antivirals **(SJ3/5 - INQ000480704)**.

e. Vaccination as a Condition of Deployment policy by way of introduction of legislation and then implementation of the policy **(SJ3/6 - INQ000257254).**

9. These ran alongside the other key decisions I was making concerning the Covid response, some of which involved vaccination, for example the requirements for vaccination for entry to various public venues in the UK (such as theatres etc), which I set out at paragraph 28 of my witness statement for Module 2.

> *"28. In my opinion, the "key" decisions which were taken during my time as the Secretary of State relevant to the Covid response (some of which involved No 10 and the Cabinet making the decision, and some did not) were:*
>
> *(a) Decisions on and about international travel - both those leaving the UK and for international travellers, involving placing various countries on the "traffic light system," and vaccine recognition for those vaccinated abroad. There were a significant number of decisions made about these issues throughout the summer and into the winter of 2021 [For example: SJ/11: INQ000092045; SJ/12 INQ000092090].*
>
> *(b) The NHS Covid 19 pass and use of it [For example: SJ/13: INQ000237535; SJ/14: INQ000146802].*
>
> *(c) Domestic policy on the need for vaccination for entry to places within the UK.*
>
> *(d) Decisions on administering booster vaccinations and the prioritisation of such vaccines for ages 12 to 15 in the Autumn of 2021 [SJ/15: INQ000091995; SJ/16: INQ000092112].*
>
> *(e) "Step 4" decision to remove many restrictions on 19 July 2021 [SJ/17: INQ000088901; SJ/18: INQ000092214; SJ/19: INQ000088903; SJ/20: INQ000092034].*
>
> *(f) The decision to offer vaccination both to those aged 12-17 (made in July 2021) [SJ/21: INQ0000921731 and those aged 5-11 [SJ/22: INQ000112226; SJ/23: INQ000074843] (made in February 2022).*

(g) The decision made to end the shielding programme and the policies in respect of those identified as "Clinically Extremely Vulnerable" (made in September 2021) [SJ/24: INQ000092105].

(h) Changes made to self-isolation for those who were fully vaccinated [SJ/25: INQ000064021; SJ/26: INQ000092992].

(i) Additional money for the NHS to support it during the winter of 2021 and the "winter plan 2021" for the NHS (an additional £5.4 billion was allocated to the NHS to support the Covid 19 response)

(j) The Autumn and Winter response to Covid 19 - Plan published on 14 September 2021 [SJ/16: INQ000092112]

(k) The setting up of the UK Health Security Agency (UKHSA) and transfer of functions into UKHSA and from PHE to the Department, NHSE and NHS Digital, including the launch of the Office for Health Improvement and Disparities (OHID)

(l) The Omicron variant including (a) travel restrictions and (b) measures to contain the variant including whether or not mandatory restrictions should be reimposed, (c) the need for booster vaccinations for all those over the age of 18, and an additional dose for those who were immunosuppressed and (d) procurement of relevant anti-virals (where there were many and daily meetings from the end of November 2021 - February 2022) (Examples of major decisions include, for example: [SJ/27: INQ000092181; SJ/28 INQ000092199; SJ/29: INQ000092197; SJ/30: INQ000091584; SJ/31: INQ000091593]

(m)The Living with Covid Plan issued in February 2022 [SJ/32: INQ000086652]"

10. As Secretary of State my role was wide ranging and included the following:

a. to seek the funding for new research.

b. to authorize the approval of vaccines and antivirals from manufacturers.

c. to take advice from the MHRA, JCVI and other expert bodies.

d. to make decisions about the vaccination programme.

e. to ensure that the deployment of the vaccine was effective.

f. to ensure that there was good uptake of the vaccine, including oversight of campaigns and communications to encourage vaccination and to seek the funding to pay for all of this activity.

11. I was also responsible for holding the other parts of the health system to account in respect of their own involvement, in particular UKHSA and the NHSE.

12. The government's policy was to vaccinate as a significant mechanism to stop the virus and to also enable fewer restrictions and less social isolation. It was therefore incredibly important not just for the health of the nation (which was paramount) but also to ensure that the economy could open.

Ways of working

13. During my time as Health Secretary, there were a rhythm of meetings which I would attend regularly. There was a "Gold" meeting on a weekly basis which took place within the Department involving myself, the CMO's and senior officials alongside UKHSA, NHS England and other bodies if needed. During that meeting, we would frequently discuss matters relating to vaccination and therapeutics as part of our wider work on Covid-19 about vaccine delivery would also have a daily meeting with the vaccine delivery team to discuss vaccination uptake and to identify what more needed to be done **(SJ3/7 - INQ000480676)**. That would include those from the Department, the NHS, Jonathan Van Tam (as the DCMO with responsibility for vaccines) and members of the UKHSA team. The discussion in that meeting would cover all aspects of vaccine delivery from arrival of the vaccine through to how they were being delivered on the ground, and to any changes that would need to be made to make the roll out more effective.

14. Alongside that, I would have meetings with the PM and the Treasury at Covid S meetings to discuss strategy including about vaccinations **(SJ3/8 - INQ000480693)**.

15. The Department's overall strategy to manage Covid was the "Battleplan" when I was in office. A version was produced on 30 June 2021 (version 4.2) which had both vaccines, treatments and antivirals as central parts of that plan. Further iterations of the plan were produced on 20 September 2021 (version 5.1), Version 5.3 on 11 October 2021and then Version 6.0 on 28 April 2022 **(SJ3/9 - INQ000480703)**.

16. When Omicron arrived in the UK from November 2021 a significant part of everyday (including weekends) would be spent dealing with issues arising from the need to take urgent steps; largely but not exclusively focused upon vaccination boosters being administered as quickly as possible. I would spend large periods of time focused upon communications around and delivery of the vaccine booster programme.

17. Alongside me I had a Vaccines Minister in post for much of my time in office, at first Nadim Zahawi (Until September 15, 2021) and then Maggie Throup (from September 15, 2021). They would attend meetings alongside, or instead of me and worked day to day on all these issues. They would also be responsible for making some statements in Parliament on vaccination issues, to deal with Parliamentary debates on the subject and to assist in communications.

18. I had a weekly meeting with the devolved administrations where we would discuss relevant issues related to Covid, which invariably involved issues concerning vaccination and sometimes therapeutics. We would share data about vaccination roll out and uptake, share best practice and identify any particular problems we were having to see if collaboration would assist in solving them. I exhibit a sample of read outs of these meetings, **(SJ3/10 - INQ000279869).** I felt that being open, transparent, and wanting to share ideas and thoughts was necessary to ensure appropriate and consistent decision making and then actions.

Development, procurement, manufacture and approval

19. I was not involved in the original procurement of the vaccines and the vaccine programme from its initiation and the relevant taskforces (such as the VTF) were all in place and operating when I came into office. I cannot therefore comment on the

public/private sector collaboration or procurement, the contractual arrangements or other variations save in general terms, nor about the knowledge of Whitehall as to manufacturing of vaccines or the relationship between the EU and the UK in respect of export controls. By the time I became Secretary of State, the DHSC and other bodies were familiar with vaccine manufacture and supply and so I cannot comment as to the state of knowledge of the Department before mid-2022.

20. I was involved in discussions with Moderna about building a MRNA vaccination manufacturing centre in the United Kingdom, including visiting them in the United States. The UK government signed an agreement with them to build such a facility and to develop training and skills development as part of this facility, with constructions scheduled to be completed by 2025 **(SJ3/11 - INQ000480702), (SJ3/12 - INQ000480707)**.

Treasury funding

21. I made some general observations about the approach taken by the Treasury to pandemic funding in my witness statement for Module 2 of this Inquiry. As someone who had held Ministerial positions in the Treasury over a period, culminating in being appointed Chancellor of the Exchequer, I had direct experience of working in the Treasury and in understanding their "world view". I said this at paragraph 32 of my witness statement for Module 2 that:

> *"I also consider that Covid showed us how flexible, radical, and innovative governing could be, and that this should be used to go forward when policy making and delivering services. There are often accusations that the executive is sclerotic and decision making is slow. There is also a view that the civil service is generally risk averse. But during the pandemic, to a large measure the "rule book" was thrown out of the window. To give an example, I cannot conceive that, absent a crisis, the Treasury would have funded the development of 8 or 9 vaccines as they did during Covid, knowing that many of them may not be successful or come to fruition. That crisis enabled the Treasury and others to take a riskier approach, knowing that not all of the funding would necessarily lead to a vaccine because the alternative was to prolong the pandemic. I would like to see that sort of radicalism become orthodox even where there is not a crisis."*

22. I cannot add more than that. It is necessary, particularly with technological development and funding of various industries for the government to be able to take risks. Caution does not breed the innovation that we need both to meet pandemics but also to grow our industrial and technological base. Medicine is becoming increasingly dependent upon technological developments, and I would like the Treasury to adopt the same approach in the future as it did during Covid.

23. I saw firsthand that the approach to funding the vaccine and the willingness to take risks did not even last the length of the pandemic. As I explain later in this witness statement, I struggled to get the relevant financing from the Treasury for antivirals in the timescales required in September 2021. I said this at paragraph 121 of my witness statement for Module 2:

> *"I have identified above the difficulties I had with the Treasury approving spending for anti-virals and testing during the Omicron variant. By this stage in the pandemic, the Treasury was seemingly no longer adopting a view of paying whatever was needed to solve the problem before examining its efficacy with more scrutiny and time. I recognise that the Treasury does have a role in assessing value for money and effectiveness, but I felt that by the time we had satisfied the various tests required by the Treasury we would not be able to order the goods."*

24. I set out the chain of events below, but consider that, in the circumstances, it is not helpful to adopt an overly risk adverse approach, particularly when the drugs concerned had been seen as necessary by a multitude of experts. The Treasury should not automatically presume that it needs to conduct further value for money assessments, or that such is required. I am aware that spending departments are seen by the Treasury as constantly demanding money, but particularly in this instance, such monies were necessary and valuable.

25. I am asked about an observation I made about the 8.30 meetings which were held at No 10 with the Prime Minister and his advisers daily to discuss Covid issues. said this at paragraph 41 of my witness statement for Module 2:

"*Occasionally, a decision would be taken in this meeting, and it would then change without any explanation. Sometimes this would be on things which were not very important, but on other matters there were sometimes changes which had significant impacts (such as changing the date by which the vaccines were to be procured).*"

26. It is not possible for me to identify to which issues this happened. It was part and parcel of the way in which the Prime Minister did business, which was to change his mind on occasions. As I identified in Module 2, this was frustrating. Coupled with the Prime Minister's tendency to "swing" in his approach to the pandemic, from being very concerned to keep individuals safe to them wanting to open up and take significant health risks, made decision making more unpredictable, inconsistent and challenging that it needed to be. I am also asked about observations by Kate Bingham & Tim Hames, in The Long Shot, to which I have nothing to say about this and cannot comment. The disposition of the Prime Minister has been well-documented by journalists, MP's and former advisers on issues beyond the pandemic.

27. I am asked about vaccine passports and No 10 decision making in that respect. At paragraph 42 of my witness statement for Module 2, I said the following:

"I recall two areas in particular where I considered that key decisions were being changed by the Prime Minister, firstly the wearing of masks and secondly the vaccine passports. ….Attitudes towards vaccine passports changed significantly in no 10 during a time of political pressure".

28. I am asked about the position in respect of vaccine passports and what the changes were. By vaccine passports, I mean the scheme for vaccine certification for entry into various venues within England i.e. to demonstrate that you have been vaccinated. The decisions as to the vaccine passports were being led by the Cabinet Office and No 10. Whilst the DHSC was consulted, it was not a policy promulgated by them. I do not remember any discussions in July 2021 about mandatory domestic use of certification or discussions about mandatory vaccination in nightclubs and other large capacity venues. I do remember meetings I would have attended with the Prime

Minister and the Secretaries of State for the relevant departments (such as the Chancellor of the Exchequer, Rishi Sunak and Kwasi Kwarteng the then Business Secretary) when preparations were being taken in September 2021 to decide the winter plan for that period of time. I remember pushing hard for vaccination or a test to be seen as required for entry. As one of the Secretaries of State I was involved, but so were other Departments. My role was to be the voice which emphasised the health aspects of decision making – so that I would always be the person who sought to ensure that the public health aspects of decisions were considered, but this would be balanced by input from other ministers who would emphasise the groups represented by their departments e.g. business owners.

29. It was also the case that people voluntarily chose to show that they had been vaccinated by the NHS App even though there was no mandatory certification required **(SJ3/13 - INQ000497211)**.

30. I am asked about the change in public messaging about vaccine passports. I would identify that the changes of position (not based upon changes in the science) did make the government seem indecisive. I consider that the government and the country could have benefited from more decisive and persistent decision making. The messages in particular about mask wearing seemed to vary (and not because of changes in evidence) and that was problematic. There were issues, however, which did need to change on the basis of the latest evidence (see below on vaccination as a condition of deployment) and I would defend the government's change of position in this respect. I am aware that this meant that policies and guidance would therefore change, often at short notice, but that was needed to respond – in particular during my time as Secretary of State – to the new omicron variant.

Authorisation process for vaccines

31. As Secretary of State, the MHRA provide advice to me (following advice they have followed as to whether they have licensed a vaccine and its efficacy, safety and quality. The witness statement of Clara Swinson Module 4A sets out the remit and role of the MHRA at paragraphs 76. The MHRA decides whether all medicines which are sold or used in the United Kingdom should be granted a licence – which they call a market authorization, and also vary licences for such medicines as information about them

develops. The DHSC then decides if they should be purchased for the UK, and the National Institute for Clinical Excellence (commonly known as NICE) decides whether medicines or other forms of clinical treatment should be provided by the NHS in the United Kingdom.

32. The MHRA advice is informed by the advice given by the Committee on Human Medicines, but it also has a duty to advise me on the safety, quality or efficacy of medicinal products given to humans. I exhibit the following advice given directly to me by the CHM during my time in office **(SJ3/14 - INQ000309497).**

33. During the pandemic, a junior Minister took decisions on licensing vaccines on behalf of the Secretary of State for Health and Social Care (firstly, Lord Bethell and then Maria Caufield or Gillian Keegan) owing to the significance of the decisions but guided by the advice from the MHRA. This happened because the Secretary of State was making decisions on the supply and roll out of vaccines, so a different Minister should make regulatory approval **(SJ3/15 - INQ000401295)** and **(SJ3/16 - INQ000401299)**, to ensure that decisions about licensing were independent of supply and purchasing decisions. An explanatory note from September 2021 sets out the principles underpinning the decisions made **(SJ3/17 - INQ000480666)**.

34. I cannot be involved in the licensing process operated by the MHRA as it is an arm's length body and operates independently of the Department to ensure independence of view. I was very impressed at how quickly the MHRA could operate its licensing approval process, in particular its conditional licensing process, something which I observed in particular in respect of antivirals.

35. I am asked about the effect of the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 amendment to Regulation 174 of the Human Medicines Regulation 2012. I was not the Secretary of State when those regulations were laid before Parliament. A review was undertaken of those regulations in 2021 and the report was published on 5 April 2022 {Regulations 174A and 247A: one year review – **(SJ3/18 - INQ000112743).**

36. The flexibility introduced by these regulations to allow expansion of the workforce who could administer vaccinations, and to also allow temporary authorisation of an

unlicensed medicine but that be made subject to conditions and safeguards. The review found that the new flexibilities were a key tool in supporting the programme of mass vaccination, and that there was broad support that the temporary authorisation did not have an adverse effect on patient safety.

37. I am asked about processes, if any, for feedback to UKHSA and other bodies for future pandemics. There were a whole host of ways in which experiences were fed back to government bodies during the pandemic, which was then fed into future planning, which are dealt with in the corporate witness statements for this Module. I do not consider that I can add any further information to that set out in those documents. When I was in office, I tried to ensure that lessons were learnt from experiences, both good and bad.

38. From my experience during the pandemic, I would say that various general lessons should be learnt as I identify later. In respect of vaccinations, I would say as follows:

    a. It is essential that we have a strong scientific base and that we provide adequate funding for research into vaccines generally. As this pandemic shows, work done in other areas can be repurposed and used successfully.

    b. We need to have a strong onshore manufacturing base for vaccines and medicines. The Moderna plant is a good step in the right direction but I very much hope that future governments will adequately fund and support the life science industry to maintain and develop manufacturing facilities within the UK.

    c. Our ability to tap into scientific advice and expertise in respect of vaccination was incredibly helpful. We need to ensure that Britain continues to produce world class scientists. Many of the scientists worked tirelessly during the pandemic on a voluntary basis for JCVI. We need, as a society, to preserve that goodwill and resource. As I describe later, I and my family were subject to threats and abuse by individuals who did not agree with the vaccination programme or the approach to Covid. So too were scientists. It is wholly unacceptable for someone who voluntarily gives up their time and energy to assist society to be vilified and abused.

d. We need to consider and develop appropriate sleeping contracts for manufacture of vaccines on a wide scale and have quick processes in place to sign them off.

e. We need to ensure and provide sufficient funding through NIHR and other scientific grants to fund and deliver vaccines, antivirals and therapeutics quickly, and to be able to set up new research in future cases, perhaps by having research ready to be activated. That research then needs to be able to be put into clinical practice quickly.

f. Our approach to spending on countermeasures for pandemics should consider not just the money to be spent, but the impact that such would have in the case of another pandemic. Sufficient insurance should be bought, including in vaccinations and therapeutics.

g. We need to maintain our ability to license treatments rapidly but with rigour.

h. We need co-ordination and co-operation between the devolved nations on the issue of vaccination where possible.

i. Build cross-party consensus where possible.

Prophylactics

39. I was provided with advice about the procurement of antibody cocktails, including Evusheld to be used as a prophylaxis from my officials who would have sought advice from the bodies and organisations, I set out below in May 2022. I was not aware of any decision making around Evusheld before I became Secretary of State for Health and cannot remember if I was provided with any advice about Rapid C-19 and Evusheld procurement in February 2022 **(SJ3/19 - INQ000497216)**. The VTF and the ATTF sought to identify such treatments. AstraZeneca were developing a treatment to be used as a Prophylaxis to be used for those who were immune compromised in some way enabling them to live a less socially restricted life. The clinical efficiency of this drug was assessed by RAPID C-19 – the organisation set up by NICE working

with NHSE E, the MHRA, NIHCR and the devolved administrations, alongside the NHS National Expert Policy Working Group and the Prophylaxis oversight group alongside the ATTF to monitor the trial evidence. AstraZeneca were seeking to have the UK government procure this drug (which was a pre prophylaxis treatment), and whether the UK should enter into an advance purchase agreement to secure supply in advance of the usual regulatory assessments undertaken by the MHRA and NICE. I was aware that the VTF had advised that this should take place for some other forms of anti-viral.

40. Their advice to the CMO in May 2022 was that evidence was insufficient to warrant progress to give access to patients and more evidence was needed of its efficacy against new variants of Covid **(SJ3/20 - INQ000480699), (SJ3/21 - INQ000489918), (SJ3/22 - INQ000480700):** details of the evaluation process are set out at **(SJ3/23 - INQ000391257).** The advice I was given in June 2022 **(SJ3/24 - INQ000497087)** was that it was too expensive for the advantages it would give. There had been a small trial of it by the time I came into office and a decision was made by the ministerial team not to procure this on 28 June 2022. I was getting a lot of pressure in Parliament to purchase Evusheld, but I was given clear advice that it was not value for money relative to other key priorities. I did not have the fiscal headroom given the very tight budgetary settlement that I had been given to procure this drug without additional money from the Treasury, which was not forthcoming. My budget settlement did not include prophylaxis or other therapeutics. In order to fund Evusheld, I would have had to cut hundreds of millions of pounds from other parts of the health budget, for a potentially indefinite period of time. I had to accept significant spending reductions (in certain areas) during my tenure as Health Secretary, as I discuss at paragraphs 126 of the Module 2 witness statement.

> "*126. Again, the then Prime Minister did not want to recognise or accept that maintaining this level of Covid response would therefore mean that other cuts would be needed to the health budget, and I did not want those health cuts to take place. In this situation, the Prime Minister is the adjudicator or arbitrator between different spending departments when deciding how any spending reductions should be allocated. Each department and its Secretary of State seeks to protect its budget as far as possible. I went to the Prime Minister to say that if he wanted to maintain the health budget and not have cuts to continue with the necessary*

infrastructure for the possibility of a future surge in Covid then it was his responsibility to go to other spending departments and to "move" the money from that department to the Health budget, as the envelope of spending could no be any larger. This is how budgetary allocations work in Government. The Prime Minister however wanted to have his cake and eat it - to reduce the overall budget whilst not cutting any programmes or spending. That was not feasible but was the position which was adopted."

41. I am asked whether or not if clinical efficacy of Evusheld could be proven, whether it would be funded by the Treasury. This is a hypothetical question as this did not arise, but as I identified above, the cost of therapeutic and anti-viral drugs was expected to come from my spending envelope – so that funding Evusheld – unless the Treasury agreed to fund it in addition to the spending of the Department, it would be funded from making savings elsewhere. As this situation did not present itself, I cannot speculate what the position would have been in that situation, but as can be seen from the information within this witness statement, I did seek to fund therapeutics, anti-viral and other medicines which would assist wherever possible. It should also be remembered that NHS England make decisions whether to deploy the medicine, so that even if I were to fund it, they would not necessarily use it, unless there was clear evidence of effectiveness against the Omicron variant.

42. I personally sought a meeting, which took place on 4 July 2022 **(SJ3/25 - INQ000497092)** and briefing notes at **(SJ3/26 - INQ000497217)** with those from AstraZeneca to discuss the decision. AstraZeneca considered that the view of those who had advised me that it was not value for money was wrong. This meeting involved two individuals from AstraZeneca (the head of UK – Tom Keith Roache and Sir Menelaos Pangalos who was head of research and development for biopharmaceuticals at AstraZeneca). Charlotte Taylor, who was the acting director of the antiviral and therapeutic taskforce for the VTF was also there. Our thinking in having this meeting and generally on the issue of Evusheld (as I remember) that there was a trial going on and I wanted to try and reach some kind of financial accommodation with the organisation about the funding of this trial. AstraZeneca had previously expressed interest in a "no risk" procurement option with NHE England, and I remember that AstraZeneca were open to having a situation where the drug was

supplied to the UK, and if the trials showed that it was not effective, then we would have the money spent on Evusheld returned to us.

43. The advice I was receiving from officials and technical advisors was that there was not sufficient evidence that it worked. I was being given pressure by parliamentarians who were keen that the UK government purchased it but the firm advice I was given was that its clinical effectiveness against the Omicron variant was not sufficiently good to suggest purchasing it in advance of all the relevant regulatory hurdles being overtaken. My understanding was that AstraZeneca were keen to have the UK government purchase this prophylaxis as it was helpful to them in their negotiations with other countries, and it was unhelpful for the UK not to purchase it from a UK based company. At the meeting on 4 July 2022, AstraZeneca indicated that they may be willing to come to some form of arrangement to mitigate the financial risk to the government if Evusheld were not effective, and that the ATTF were to work with AstraZeneca for a commercially and clinically feasible real world study for a small number of doses, and then further doses would only be ordered if found to be clinically feasible **(SJ3/25 - INQ000497092) (SJ3/27 - INQ000497091)**.

44. I then resigned the following week, so I was not involved from that point forward.

45. I sent a WhatsApp message to my successor, Steve Barclay on 13 August 2022 **(SJ3/28 - INQ000327491, page 5-6)** at which I asked him why he announced that he was not proceeding with Evusheld given the broad agreement I had reached with AstraZeneca. When I say in this WhatsApp that a "deal was agreed," I mean that AstraZeneca were open to the idea of "no success: no fee" arrangement as described in the meeting held in late June 2022. There was no contractual arrangement signed and obviously it would have been subject to the relevant legal advice, that there was no issue of state aid, that it was not in breach of any procurement regulations. Even if it had crossed all those hurdles, I would still have had to find the money internally at the DHSC to fund it. Had I remained in office, I think that I would have sought to agree some kind of deal with AstraZeneca whereby the government would have paid only 10% of the cost, Leva when the contract was agreed and then postpone the rest of the payment until the trials had been completed. This would have required agreement from the Treasury as it would have required a significant amount of spending.

46. I am asked what I meant by a "big breakthrough" in that's WhatsApp – that would have been that both sides recognised that some kind of deferred payment or return of monies had been agreed and that "both sides" in the context of this WhatsApp meant AstraZeneca and the Department of Health and Social Care.

47. I had no further communications with Steve Barclay or others on this topic (that I can recollect) subsequent to this WhatsApp message.

48. I was aware that other European Countries used Evusheld and other forms of "Prep" prophylaxis, and that other countries brought and used it. I recognise that it was also embarrassing for the UK government not to be purchasing such prophylaxis from a company which was British in origin, and that politically it would have been easier to disregard the evidence presented. You cannot help but consider what impact these decisions may have, for example, on the development of life science manufacturing in the UK in the future. I also note, however, that the USA did not use Evusheld for emergency use evidence emerged that it was not effective against newer Covid 19 variants **(SJ3/29 - INQ000480706)**.

49. I have been asked to comment upon the observation made by Kate Bingham in her book the Long Shot that she was "flabbergasted" that they did not want to procure these therapeutics. I have nothing further to add than I set out above.

Eligibility and prioritization

50. I received advice from the JCVI about eligibility and prioritization of the vaccine for Covid (and other vaccinations). The JCVI was the expert body set up under statute to advise on all vaccinations in England and Wales. I would need an exceptional reason to depart from their recommendations and did not do so. I followed their recommendations as to do otherwise public confidence would be undermined, and it was clear that they had significant expertise in this subject area, and their very purpose was to provide me with high quality reasoned advice.

51. The role of the DHSC is to ask the JCVI for advice and guidance on vaccinations, and then let them debate, discuss and collate the relevant data, scientific advice and expert opinion to provide me with a reasoned piece of advice.

52. I am asked if I instructed the JCVI to give certain advice. I did not issue instructions but did ask for advice. I am also asked whether I "instructed" JCVI in providing its advice to consider safeguarding to ensure fair treatment of unpopular or vulnerable groups in eligibility and prioritisation. I was not in post when decisions were made about prioritisation for phase 1 of vaccination. My view was that the JCVI considered these issues as a matter of routine. My role was to make sure that all groups got equal access to the vaccine, and that those who would be most affected if they caught Covid were given priority. I am aware that various groups considered that they should have had priority over others: I was not in post when the prioritisation first took place but I consider that it sought to conscientiously consider this and to balance competing priorities in a way which sought to prevent death and serious illness. As to providing advice to consider the effect of existing inequalities, I asked for advice which reflected the risks of certain individuals becoming more unwell if they did not have a vaccination.

53. I expressly and vocally indicated that everyone should have the vaccine, regardless of background, migration status or other status. To give a number of specific examples, I expressly instructed all vaccination centres not to request or require any paperwork from anyone – so that those who may be in the country illegally were not prevented from attending **(SJ3/30 - INQ000480709), (SJ3/31 - INQ000480650)**. I also instructed that the communications issued should make it clear that everyone should get the vaccine no matter what their immigration status. I was aware of fears of those who were irregular migrants that they would be affected if they used health services. I wanted to make sure they felt able to come forward and have their vaccination.

54. I also spent time seeking to encourage those from groups with lower uptake to take the vaccination, both directly and indirectly. This included specific work on those from minority ethnic communities and those who were younger, where take up rates were much lower, including producing health and communication materials in a variety of languages and using a variety of forums – for example social media. I also sought to ensure that the vaccine went to all parts of every community – so that vaccinators went to those who were house bound, living in marginal communities, such as the homeless, to enable them to have the vaccine.

55. The work on vaccination uptake was led by the Minister with specific responsibility for vaccination (which in my time was Nadhim Zahawi and then Maggie Throup) whose role was to lead on this. My role was to ask the right questions and to ask for updates. Much of the work that I personally undertook on this topic was to undertake media appearances, alongside seeking to make sure that the Department, but also NHS England and all those involved in the deployment of the vaccine on the ground had taken steps to increase the uptake of vaccinations. To give an example, on 22 December 2021 Maggie Throup and I asked for statistics on the number of people from black and minority ethnic backgrounds who were not vaccinated, and on the "messaging" about increasing uptake **(SJ3/32 - INQ000497212)**. To give another example, I specifically asked the team when Ramadan was approaching to ensure that there were specific communications and advice from Muslim clerics and scholars to give advice about being vaccinated whilst fasting, and to quash false rumours about having porcine components in such vaccinations.

56. There was not one person in charge of increasing vaccine uptake in these communities: it was an effort shared amongst all those working on vaccination, from myself as Secretary of State through to the communications teams, to those on the ground delivering vaccines.

57. The Devolved Administrations worked very well and in tandem with us in respect of JCVI advice, as of course the JCVI is a UK advisory body. I would see the JCVI advice before it was published. The devolved administrations would also see this advice as they had representatives on the committee. I had a weekly meeting with the health Ministers of the devolved administrations during which we would discuss any JCVI advice, see for examples **(SJ3/33 - INQ000279851), (SJ3/34 - INQ000279853), (SJ3/35 - INQ000309495), (SJ3/36 - INQ000309515),** but we would also have specific meetings to take them through the various pieces of advice given. This was done to see if consensus would be reached as to the steps to be taken after the advice was delivered. In every case, all four nations agreed to the same approach in respect of vaccination. I consider that we worked well together, approaching things from the same point of view and recognising the need for commonality of approach to give public confidence. This was not just on vaccination but on many other areas concerning Covid, and we had a good level of trust between us so that we would speak

informally, as well as formally, for example **(SJ3/37 - INQ000309526, SJ3/38 - INQ000309504)**.

58. There was only one occasion I remember when I had concern about the behaviour of the Scottish Government concerned the vaccination of children aged 5-11. I considered that as this was an issue which had raised public debate and discussion, and in order to maintain confidence from the public, there should be consistent messaging and central communications about the advice given by the JCVI and the steps that the government were taking. I had heard, via backchannels that Nicola Sturgeon wanted to announce the policy prior to it being fully ready for a four nation roll out with relevant scientists, information sheets and communications all being put in place. I telephoned the Health Minister at the time (Hamza Yousaf) to indicate that this was not an acceptable course of action. If this happened, then trust would be lost with his office, given he had agreed to this four-nation communal information campaign. I would have to then deal with Ms. Sturgeon's office directly. Mr. Yousaf acted very swiftly and resolved the issue, and the matter was announced in concert.

59. I would also always speak with the shadow health secretaries of state before the decision became public to explain it to them and ask them to support me. On every occasion they were supportive and positive towards my approach, which I appreciated.

Ethical advice

60. I would say that ethical concerns were discussed within the Department and were part of the debate, particularly around vaccinations as a condition of deployment and as to eligibility and were central parts of the decision-making process.

61. I have been asked about what role the Moral and Ethical Advisory Group played in decision making. I cannot remember seeing any discrete advice from MEAG during my time as Secretary of State: my understanding was that any advice that officials commissioned from MEAG was integrated into other advice and so I would not necessarily have had specific advice identified as such. I understand from the sixth witness statement of Ms. Swinson for this Module (Statement A) at paragraph 110 that the MEAG advice on vaccine prioritisation and roll out predated my time as Secretary of State for Health. As far as I am aware, specific advice was not commissioned about

vaccinating young people from MEAG. JCVI was used to advising the government on vaccination of children and young people as part of the routine vaccination schedule, and so was already able to deal with the ethical issues raised.

Reducing the time for doses for Phase 2 of the Vaccination programme

62. A key decision I had to take in respect of vaccination concerned reducing the interval between doses of the vaccine **(SJ3/39 - INQ000401353), (SJ3/40 - INQ000401354)**. I was given advice about this on 2 July 2021 following on from a discussion in a "Gold" meeting about whether compressing the interval between doses should take place to try and complete vaccination of all those over 18 as quickly as possible. I agreed to this advice and it was then implemented. I always sought to make sure that any decisions about reduction in periods was clinically appropriate rather than just making life easier for everyone.

63. The Department has provided detailed information about the JCVI's role and remit (paragraphs 100 - 106) of the witness statement of Clara Swinson Module 4, Statement A and I have had sight of the second witness statement of Professor Wei Shin Lim who sets out in some detail the approach of the JCVI to its decision making and how it made its decisions.

64. My role as Secretary of State was to make the decision whether or not the JCVI's decisions were to be implemented. The decisions made by the JCVI in respect of Covid 19 without the requirement set out in Regulation 2 of the Health Protection (Vaccination Regulations 2009) **(SJ3/41 - INQ000480657)**, to undertake an assessment of cost effectiveness – because the government did not consider that this was a central feature given the impact of the pandemic on the whole of UK society and so I was not legally required to implement the JCVI recommendations. However, I viewed it as my role to give significant weight to the recommendations advanced by them, and I followed their advice and recommendations in the decisions I made.

65. The advice I was given by my officials included the relevant advice from the JCVI along with other relevant material that I would need to consider in the implementation of that decision. That included as a matter of routine advice on the impact under s149 of the Equality Act 2010 – the public sector equality duty, the test as to the impact of the

advice upon families and an assessment of the impact under Part 1 of the NHS Act 2006 which involved my ability to make directions (if I chose) to bodies concerning public health and the provision of NHS services. I would also receive advice as to whether there would need to be any primary or secondary legislation issued to reflect the decision made.

66. If it was a significant decision that needed to be made, then I would call the Shadow Health Secretary, on Privy Council terms (meaning it was in the national interest and needed to be kept strictly private), explaining the advice I received. I would then tell them that I planned to make a statement in Parliament. Most of the time I would make the statement myself or the Vaccine Minister would do it, but in either event I would be the one calling my opposite number. One of the key reasons for this process was to maintain vaccine confidence; it was not a matter for party politics. Once I had made decisions about vaccinations, my officials would then draw up a written Ministerial statement that I would approve or I would give an oral statement in the House of Commons. This is done to make sure that Parliament knows of my decisions and that it is on the official record and in the public domain. Alongside this, I would also send a letter to the Public Accounts Committee required under parliamentary convention and also send what was called a "Departmental Minute" **(SJ3/42 - INQ000257428)**. This is a document which is sent to Parliament by me identifying that the Department has authorized spending of over £300,000, for which there is no specific statutory authority. I had to explain what the spending concerned and why I was spending it. In usual circumstances, the Department would not then spend the money until after 14 Parliamentary sitting days so that if there was a concern raised in Parliament it could be addressed. Given the need for speed in vaccination uptake and roll out, we did not follow this convention.

67. I would also have to approve the national protocol issued by the PHE/UKHSA (pursuant to my responsibilities under Regulation 247A of the Human Medicine Regulations 2012). These are documents developed by PHE/UKHSA to allow for an agreed safe way to administer a particular vaccine. An example of which is **(SJ3/43 - INQ00067006)**. This is known as the Green Book and sets out the advice and guidance to all those concerned with vaccination in the NHS and public health system.

Vaccination of young people

68. The decision to vaccinate young people was a significant decision for me. The Department recognized that; with the advent of widespread vaccination across the world for those over the age of twelve, it was something which the UK government would need to consider.

69. The JCVI had not originally recommended the vaccination of young children when the vaccination first took place in December 2020, in part because there was limited data on the impact of the vaccine on adolescents and no data on vaccination in younger children **(SJ3/44 - INQ000234638)**. The UK has, for several decades, operated an extensive childhood immunisation programme so, whilst the particular pathogen was new, the principles in respect of vaccination of children, and the particular safety requirements necessary were well known and understood throughout those developing, considering and administering vaccinations.

70. My predecessor, Matt Hancock had asked for advice on the vaccination of children on 26 May 2021 **(SJ3/45 - INQ000061025)** and had met with the Department for Education on 9 June 2021 to discuss the issue **(SJ3/46 - INQ000401350)**.

71. The Pfizer BioNTech vaccination was authorized by the MRHA for use in the UK for those aged 12 – 15 on 4 June 2021 (having been authorized for use by the European Medicines Agency in May 2021 for the same age range) **(SJ3/47 - INQ000340234)**. The Moderna vaccine was authorised by the MHRA for use in children aged 12 – 17 on 17 August 2021**(SJ3/48 - INQ000480660).**

72. By the middle of June 2021, several European countries (for example France. Hungary, Italy, Austria) as well as Israel, Singapore, Japan, Hong Kong and states in the US and Canada had either begun vaccinations or signalled that they would do so in the near future **(SJ3/49 - INQ000480652)**.

73. I always recognized that the vaccination of children and young people (i.e. those under the age of 18) would be the subject of more scrutiny and debate than that of adults. The JCVI's advice was always premised on whether or not vaccination would benefit

the child or young person receiving the vaccination: it did not make decisions based upon whether the vaccination of the child would have a benefit to a third party – such as their parent or grandparent, with whom they lived. The advice they gave was therefore not based upon the wider benefits to society of having vaccinations, as that was something that the Department and those that advised them had to consider.

74. I would describe the JCVI advice as finely balanced, given the comparatively very low risks associated with Covid 19 infection in children compared with adults. I am asked how I dealt with the advice which is described as "equivocal" by the Inquiry in respect of children. I do not think that word is appropriate. The advice was nuanced in nature because there were competing arguments. I consider that an expert advisory group tasked with advising me should not be afraid of nuance or balance even if that means that my decisions are then more complex. I go to them for frank and realistic advice grounded in their experience and the data. That does not always produce clear cut results. Science is not always clear cut, simple or straightforward and politicians and the public should not expect such. My role as the Secretary of State is to look at the wider considerations about vaccination and make a decision that takes account of and is informed by the expert scientific advice, but also to look at the wider issues, such as school absence, which were relevant to society.

75. I was aware that parents would wish to have a high level of assurance before giving their child the Covid 19 vaccine given the very low risk of severe Covid 19 in the childhood population, and in particular parents would want to be clear about the possible harms of any vaccinations and have the risks and benefits explained to them by the government. The JCVI in their approach to immunization stated that safety was paramount when reaching its conclusions.

76. My private office was sent the advice provided by the JCVI **(SJ3/15 - INQ000401295)**, **(SJ3/50 - INQ000401394) (SJ3/51 - INQ000309498).** I would have read it, alongside other briefing papers and materials supplied by the Department so I could make a decision based upon that advice. The vaccination of children and young people included advice on the legal obligations and issues surrounding parental consent required to administer the vaccination, the financial impact of the decision and equalities impact.

77. I would not have been given the research papers upon which the JCVI reached its advice but would have relied upon the material presented to me.

78. Whilst the vast majority of young people had not been vaccinated, there were some (those in the group 6 priority) aged between 16 – 18 who would have been vaccinated as they had underlying health conditions which put them at a higher risk of serious disease and mortality as advised by the JCVI in December 2020. Alongside this group, JCVI had advised on 30 December 2020 **(SJ3/52 - INQ000354469)** that those who were clinically extremely vulnerable under 16, or those at very high risk of exposure and serious outcomes, such as older children with severe neuro-disabilities that led them to living in residential care settings, should discuss the risks and benefits of vaccination with those with parental responsibility **(SJ3/53 - INQ000256951)**. This usage was "off label" i.e., there had not been regulatory approval by the MHRA of the use of the vaccine on this age group. Until August 2021 vaccination was available for those who were:

    a. Over 16 and at increased clinical risk from Covid 19.

    b. Over 16 and in receipt of carer's allowance, or the main carer of an elderly or disabled person whose welfare may at risk if the carer falls ill.

    c. Over 16 and a frontline health or social care worker.

    d. Under 16 and at high risk of exposure and serious outcomes.

79. In March 2021, the JCVI recommended that all children over twelve who are household contacts of those who are immunocompromised should be offered two doses of a vaccine and recommended that all those aged 16 and over be given an initial first dose **(SJ3/54 - INQ000401345)**. It was therefore the case that, whilst a relatively small number of children and young people had been vaccinated, the vast majority of children and young people were not included in these groups.

80. JCVI provided an interim statement on Covid 19 vaccination of children to me on 7 July 2021 recommending that specific groups of young people over twelve should be vaccinated but did not recommend universal vaccination **(SJ3/55 - INQ000061276)**. The specific groups where vaccination was advised was:

    a. Those over 12 with specific underlying health conditions that put them at risk of serious ill health by contracting Covid 19 **(SJ3/56 - INQ000411710).**

    b. Those aged 12 – 15 with severe neuro disabilities, Down's syndrome, conditions which result in immunosuppression, those with profound and multiple learning disabilities, severe learning disabilities or who were on a register of those with learning disabilities. This was because there had been studies and research which showed greater rates of mortality and hospitalization amongst this cohort **(SJ3/57 - INQ000480655).**

    c. Young people aged 16-17 who were at higher risk of serious Covid 19 (they had already been offered the vaccine as Part of Phase 1.

    d. Those aged over 12 who are household contacts of persons who are immunosuppressed were to be offered the vaccine but solely on the basis that the main benefit is not to them but to their household member.

81. I received a submission from my staff to seek agreement to the JCVI interim advice on 5 July 2021 **(SJ3/58 - INQ000309444)** and I discussed this with senior officials from the DHSC, NHS England, and the CMO's office at a meeting held on the same day. I felt that the issues were significant enough for me to explore and debate with those individuals and to consider carefully **(SJ3/59 - INQ000480653).**

82. Following on from this, I received a submission on 8 July 2021 asking me to accept the JCVI advice **(SJ3/60 - INQ000309448)** which I did on 12 July 2021 **(SJ3/61 - INQ000401359)**. This gap was due to the weekend.

83. On 29 July 2021, JCVI considered the question of vaccination of 12–17-year-olds again, looking at data from other countries **(SJ3/62 - INQ000354527).** The advice I

received on 4 August 2021 was that all 16-17 years olds should be offered a first does of the Pfizer vaccine: and that children over 12 who are household contacts of the immunosuppressed should be offered two doses of the Pfizer vaccine (cs 194 – 196) **(SJ3/63 - INQ000401363).** Alongside the JCVI advice, I received a submission from the Department asking for my agreement to this **(SJ3/64 - INQ000111662)** on 3 August 2021 which I agreed to the next day **(SJ3/65 - INQ000401364)** with the roll out beginning on 5 August 2021. Within 3 weeks, this was rolled out and all that group had been given access to the vaccination (paragraph 252 – 258 of Module 4 Statement A).

84. On 31 August 2021, I received JCVI advice on vaccinating children between 12 – 15 with underlying health conditions **(SJ3/66 - INQ000401380)**. The advice recommended vaccinations for groups, including those with sickle cell, type 1 diabetes, heart disease and a range of other conditions. I received a submission on this issue on 2 September 2021 which I agreed to later the same day **(SJ3/67 - INQ000401379), (SJ3/68 - INQ000480662)**.

85. As part and parcel of the decision, I had to approve changes to the national protocols which were issued in respect of some of the vaccines (Pfizer/BioNTech and Comirnaty – **(SJ3/69 - INQ000067888) (SJ3/70 - INQ000340257)).**

86. I then received further advice from the JCVI on 2 September 2021. I exhibit the full advice here **(SJ3/71 - INQ000066868)** along with the wider information that I was given by the Department to support my decision **(SJ3/72 - INQ000066867)**. The advice concluded that the benefits from vaccination are marginally greater than the potential known harm but acknowledged that there was considerable uncertainty regarding the magnitude of the potential harms. The margin of benefit, based primarily on a health perspective, was small to support advice on a universal programme of vaccination of otherwise healthy 12- to 15-year-old children at this time. As is set out in this advice, and also the second witness statement of Wei Shen Lim (at paragraphs 105 – 109), the JCVI were not a body charged with looking in depth at wider societal impacts, including educational benefits. One of the major disruptions to young people without vaccination was the rules around social distancing and isolation measures in schools, thus leading to, in some cases, multiple absences.

87. Because the advice from the JCVI identified the need to look at broader societal impacts I wrote to the CMO's of all four nations to ask them to consider the matter from a broader perspective **(SJ3/73 - INQ000073917).** I received their advice on 13 September 2021 **(SJ3/74 - INQ000066869)**. This advice was produced with the benefit of specialist expertise and input from relevant Royal Colleges and Public health experts and examined data on the impact of Covid on education. It also looked at data from the USA, Canada and Israel who had already vaccinated many of their 12 – 15-year-olds by September 2021.

88. I exhibit here their advice **(SJ3/74 - INQ000066869)** which was as follows:

> "**Advice**
>
> *All drugs, vaccines and surgical procedures have both risks and benefits. If the risks exceed benefits the drug, vaccine or procedure should not be advised, and a drug or vaccine will not be authorised by MHRA. If benefits exceed risks then medical practitioners may advise the drug or vaccine, but the strength of their advice will depend on the degree of benefit over risk.*
>
> *At an individual level, the view of the MHRA, the JCVI and international regulators is that there is an advantage to someone aged 12 to 15 of being vaccinated over being unvaccinated. The COVID-19 Delta variant is highly infectious and very common, so the great majority of the unvaccinated will get COVID-19. In those aged 12 to 15, COVID-19 rarely, but occasionally, leads to serious illness, hospitalisation and even less commonly death. The risks of vaccination (mainly myocarditis) are also very rare. The absolute advantage to being vaccinated in this age group is therefore small ('marginal') in the view of the JCVI. On its own the view of the JCVI is that this advantage, whilst present, is insufficient to justify a universal offer in this age group. Accepting this advice, UK CMOs looked at wider public health benefits and risks of universal vaccination in this age group to determine if this shifts the risk-benefit either way.*
>
> *Of these, the most important in this age group was impact on education. UK CMOs also considered impact on mental health and operational issues such as any possible negative impact on other vaccine programmes, noting that influenza*

vaccination and other immunisations of children and young people are well-established, important, and that the annual flu vaccine deployment programme commences imminently.

The UK CMOs, in common with the clinical and wider public health community, consider education one of the most important drivers of improved public health and mental health, and have laid this out in their advice to parents and teachers in a previous joint statement. Evidence from clinical and public health colleagues, general practice, child health and mental health consistently makes clear the massive impact that absent, or disrupted, face-to-face education has had on the welfare and mental health of many children and young people. This is despite remarkable efforts by parents and teachers to maintain education in the face of disruption.

The negative impact has been especially great in areas of relative deprivation which have been particularly badly affected by COVID-19. The effects of missed or disrupted education are even more apparent and enduring in these areas. The effects of disrupted education, or uncertainty, on mental health are well recognised. There can be lifelong effects on health if extended disruption to education leads to reduced life chances.

Whilst full closures of schools due to lockdowns is much less likely to be necessary in the next stages of the COVID-19 epidemic, UK CMOs expect the epidemic to continue to be prolonged and unpredictable. Local surges of infection, including in schools, should be anticipated for some time. Where they occur, they are likely to be disruptive.

Every effort should be taken to minimise school disruption in policy decisions and local actions. Vaccination, if deployed, should only be seen as an adjunct to other actions to maintain children and young people in secondary school and minimise further education disruption and therefore medium and longer term public health harm.

On balance however, UK CMOs judge that it is likely vaccination will help reduce transmission of COVID-19 in schools which are attended by children and young

people aged 12 to 15 years. COVID-19 is a disease which can be very effectively transmitted by mass spreading events, especially with Delta variant. Having a significant proportion of pupils vaccinated is likely to reduce the probability of such events which are likely to cause local outbreaks in, or associated with, schools. They will also reduce the chance an individual child gets COVID-19. This means vaccination is likely to reduce (but not eliminate) education disruption.

Set against this there are operational risks that COVID-19 vaccination could interfere with other, important, vaccination programmes in schools including flu vaccines.

Overall however the view of the UK CMOs is that the additional likely benefits of reducing educational disruption, and the consequent reduction in public health harm from educational disruption, on balance provide sufficient extra advantage in addition to the marginal advantage at an individual level identified by the JCVI to recommend in favour of vaccinating this group. They therefore recommend on public health grounds that Ministers extend the offer of universal vaccination with a first dose of Pfizer-BioNTech COVID-19 vaccine to all children and young people aged 12 to 15 not already covered by existing JCVI advice.

If Ministers accept this advice, UK CMOs would want the JCVI to give a view on whether, and what, second doses to give to children and young people aged 12 to 15 once more data on second doses in this age group has accrued internationally. This will not be before the spring term.

In recommending this to Ministers, UK CMOs recognise that the overwhelming benefits of vaccination for adults, where risk-benefit is very strongly in favour of vaccination for almost all groups, are not as clear-cut for children and young people aged 12 to 15. Children, young people and their parents will need to understand potential benefits, potential side effects and the balance between them.

If Ministers accept this advice, issues of consent need to take this much more balanced risk-benefit into account. UK CMOs recommend that the Royal Colleges and other professional groups are consulted in how best to present the risk-benefit decisions in a way that is accessible to children and young people as well as their

parents. A child-centred approach to communication and deployment of the vaccine should be the primary objective.

If Ministers accept this advice, it is essential that children and young people aged 12 to 15 and their parents are supported in their decisions, whatever decisions they take, and are not stigmatised either for accepting, or not accepting, the vaccination offer. Individual choice should be respected."

89. I remember that the Prime Minister was very keen on children being vaccinated and would often ask about this in our morning meetings. He would very push hard on this topic, pointing out how other countries in Europe had been doing with their vaccination programmes – for example Portugal and Spain which were pushing vaccinations in schools. He asked repeatedly why these countries were so far ahead. My response was that we were waiting for JCVI advice, and their view was that child vaccinations was not a priority topic of advice at that time. The Prime Minister asked why CMO's and JCVI could not look at this topic faster. As recognised by the CMO in their advice, my role in determining this vaccination process was to look not just at public health but also wider societal issues when deciding whether to vaccinate. I explained this nuanced approach to the Prime Minister, which he ultimately accepted. It was clear that his expectation was that we would go the same way as other European countries, and he was keen for universal child vaccinations to be rolled out, but he nonetheless understood and accepted my decision **(SJ3/75 - INQ000067276) (SJ3/76 - INQ000088905).**

90. I agreed with the advice of the CMO's that the vaccination should be offered and made the decision the same day. The departmental submission sets out the various issues raised **(SJ3/77 - INQ000401383)**. The wider advice showed that there were advantages, albeit nuanced and balanced. Given this balance and having taken advice, I did not seek to "push" the vaccination. It was an individual choice for parents, and for those who were able to have capacity to consent themselves who were under 16 to make that decision. The Department and other organisations involved in vaccination roll out did not run a public campaign exhorting parents to vaccinate their children as we considered that it was not something which was imperative for their child's health. Obviously, as is indicated, where the young people lived with those who

were immunosuppressed, or they had a particular susceptibility to the impact of Covid then the JCVI had already provided for a different vaccination schedule, and we did encourage those children and young people to have the vaccination.

91. As I wrote in my letter to MP's **(SJ3/78 - INQ000066883)** "*I want to place particular emphasis on the word "offer".. Parents and children should be supported to make a considered decision on vaccination and there should be no stigmatization or pressure for people based on the decisions that they make.*"

92. All four nations agreed this approach, and we acted in a co-ordinated manner in agreeing the advice and also the steps forward. We did so through discussions with the health Ministers, alongside officials and the regular CMO meetings.

93. I received advice on 28 November 2021 **(SJ3/79 - INQ000401391)** that second doses of the vaccine should be offered to 12 – 15 years old, which I read and agreed with the next day **(SJ3/80 - INQ000067522)** and published a Ministerial statement the following day to announce this **(SJ3/81 - INQ000257141)**.

Uptake of the 12-15 programme vaccination

94. The roll out of the vaccination programme to children was going to be primarily delivered across schools, and I know that the DHSC met with officials in the Department for Education to identify how the roll out could be delivered in schools. Even before Covid-19, the vaccination programme for children for those of school age has been operated and run by the local authority because of their duties in respect of public health. Most vaccinations for those of school age therefore take place under the school's vaccination service, rather than the vaccination centres and GP's. At first, the roll out was delivered in this way. That then changed because the schools programme alone was not able to roll out the vaccine as quickly as first anticipated, and so vaccinations could then be provided in vaccination centres, with GP's and others.

95. Alongside this, most parents needed to give their consent to the administration of the vaccination. One reason that the roll out of child vaccinations was slower than adult vaccinations was this issue of consent. A process needed to be set up so that it could take place in an efficient way. This had to be discussed with local authorities and with

the Department for Education. Alongside this, there was also the issue of misinformation on vaccines in schools which made rolling out the programme more difficult.

96. As part of decision making throughout the pandemic, the Cabinet Office co-ordinated much of the work of the departments, including the vaccination unit. The Prime Minister also saw vaccination as one of his top priorities and so would want regular updates and discussions about how to increase vaccination uptake, see for example **(SJ3/82 - INQ000089038)**.

97. As part of this decision-making process, something called a "red team" session would be organized on occasions on different areas of policy. A "red team" is a way of creating critical thinking within decision making and to seek, either by way of an internal "mindset" or by way of creating external challenge **(SJ3/83 - INQ000480690).** The DHSC, including myself and the Cabinet Office, Department for Education and NHS England undertook such a session in October 2021 **(SJ3/84 - INQ000489916), (SJ3/85 - INQ000480672), (SJ3/86 - INQ000480673), (SJ3/87 - INQ000480674)**. We undertook this as we knew with the onset of Autumn the transmission of Covid would rise and we wanted to limit, so far as practicable, unnecessary time off school and to minimize the social isolation measures.

98. Following this, a decision was taken to seek to accelerate the 12-15 vaccination programme **(SJ3/75 - INQ000067276)** using existing adult vaccination infrastructure during the autumn half term of 2021. Before that point, we had been relying upon the school's vaccination service to provide vaccinations at school and had realized that would take longer to roll out than anticipated **(SJ3/88 - INQ000480668).** I looked at the Scottish experience where there had been far greater levels of vaccination by mid-October 2021, because they were using both in school vaccination services and out of school vaccination services, and so we pivoted on how we were rolling out the vaccine to reflect the need to provide vaccination not just in a school setting.

99. We also took steps to improve the programme on offer by seeking to make the vaccination more efficient to administer and to increase workforce capacity to do so.

We also appointed a senior responsible officer Nick Hulme (in mid-October 2021) who took charge of the 12 – 15 vaccination programme **(SJ3/76 - INQ000088905).**

100. As well as seeking to improve the number of vaccination slots we could offer to those aged 12-15, we also sought to provide more information to parents and children on the value and safety of the vaccination with relevant information **(SJ3/89 - INQ000480670), (SJ3/90 - INQ000480669)**.

101. From January 2022, there was the roll out of the booster to 12-15 years old, and to those under 12 who were in a clinical risk group (see paragraph 113 below).

Third primary dose of Covid 19

102. On 27 August 2021, I received advice from the JCVI on whether I should provide a third primary dose to those who were sever immunosuppressed, alongside advice from the Department. I agreed with that advice, and on 28 August 2021, this vaccination was offered to that cohort **(SJ3/91 - INQ000066756), (SJ3/92 - INQ000066757), (SJ3/93 - INQ000066760), (SJ3/94 - INQ000066759), (SJ3/95 - INQ000066761), (SJ3/96 - INQ000066758), (SJ3/97 - INQ000066762)**. I read both the primary advice and the additional material including the JCVI statement, the public sector equalities, families and statutory impact advice.

Covid 19 booster vaccinations to those who had received their first dose

103. Alongside the decision making set out above, the JCVI also advised as to the need for booster vaccinations for those who had already received a primary course of vaccination at least 6 months ago. The JCVI advice was to provide a booster for the priority groups 1-9 (as described in the corporate witness statement Module 4 statement A paragraph 214-215 and the accompanying table sets out cohorts 1-9). I agreed with this recommendation on 13 September 2021 **(SJ3/98 - INQ000066881)**.

104. This vaccination took place alongside the roll out of the vaccine to 12–15-year-olds. The advice I was given by the CMO office, the CSA and the UKHSA was that these booster vaccinations were the clinical priority, along with reaching those already unvaccinated, as it was these vaccinations that would have the greatest chance of cutting mortality and minimizing hospital admissions.

Booster vaccinations and Omicron – intervals for dosage

105. I remember that when the Omicron variant came to the United Kingdom, we were, at first, very concerned that the vaccine may well not work (or not work as well) against Omicron. I was also concerned that the roll out for the "third jab" meant that individuals had to have a three-month gap between the second dose and the booster.

106. Whilst those who were over 65 would have had that gap by November 2020, that would not have been the case for the younger age groups. I had determined, after receiving advice, that we needed to try and boost at least half the adult population before Christmas (which was only a four-to-five-week period) and that to do so we needed to reduce the period of vaccination from 6 months to 3 months if at all possible **(SJ3/79 - INQ000401391).**

107. To that end, I asked for emergency advice over the weekend of 27 – 28 November 2021 from the JCVI, via the Chief Medical Officer, to see if the gap could be reduced. The JCVI then worked all weekend to produce this advice which advised reducing the gap, and that a booster could be available to anyone over the age of 18. At the same time as JCVI were working on their advice, the delivery team were also working on increasing the number of booster jabs which could be offered.

Information to Parliamentarians

108. Alongside information to the public and placing matters on the record in Parliament, the Vaccines Minister and I wrote to all MP's about the vaccination of those aged 12-15 and also the third booster in order to provide them with our decision **(SJ3/99- INQ000066833)**. Other examples of this include **(SJ3/78 - INQ000066883).**

Covid clinical trials

109. On 30 September 2021 **(SJ3/100 - INQ000067225), (SJ3/101 - INQ000067229) (SJ3/102 - INQ000067226)**, I approved additional Covid 19 doses for clinical triallists in line with the advice I received.

Second dose of vaccination for 16 – 17-year-olds

110. JCVI produced advice which was sent to me on 9 November 2021 accompanied by advice from the Department which recommended that second doses of vaccines should be offered to 16–17-year-olds **(SJ3/103 - INQ000111950).** I accepted this on 11 November 2021 **(SJ3/104 - INQ000067401)**. Once the decision had been made a Ministerial statement was published to announce the change, and the JCVI published its advice both on 15 November 2021 **(SJ3/105 - INQ000354546)**. I also wrote to Parliamentarians **(SJ3/106 - INQ000401390)**.

Booster jab for those 16-17 and children in a high-risk group

111. Those aged 16 – 17, or who either were severely immunosuppressed and who had a third primary dose, or who were 12-15, or were in a high-risk group or were a household contact of someone who is immunosuppressed had received doses of the vaccine earlier in 2021 **(SJ3/52 - INQ000354469).**

112. JCVI recommended that a booster vaccine be offered to these individuals, which I accepted on 16 December 2021 **(SJ3/14 - INQ000480686).** JCVI advised and I wrote to all MP's along with the Vaccines Minister **(SJ3/107 - INQ000480685).**

Vaccination of those under the age of 12

113. Pfizer receive approval in the US for vaccination of children aged 5-11 on 29 October 2021 **(SJ3/108 - INQ000480677).** Both they and Moderna applied to the EMA for the approval of vaccinations for the under 12's **(SJ3/109 - INQ000480675), (SJ3/110 - INQ000480681), (SJ3/111 - INQ000480694)**, and it was expected that, if the EMA approved their applications, that an application would then be made to the MHRA to seek their approval.

114. I was keen to make sure that, if vaccination was approved for this age group, then there could be swift deployment. I therefore wrote to the Chair of the JCVI on 12 November 2021 asking for their initial advice on providing a primary does to those under the age of 12 **(SJ3/112 - INQ000067404).**

115. JCVI reviewed the evidence and sent me a submission on 16 February 2022 **(SJ3/113 - INQ000257287),** which advised that the vaccination programme should be extended to those aged 5-11. Again, this advice was based upon the health benefits of vaccination in the age group, the potential educational benefits (from fewer periods of social isolation caused by outbreaks of Covid in school settings) and the impact on the NHS of delivering a programme to around 5 million children.

116. The advice from JCVI was a non-urgent offer of a two-dose vaccine (with an interval of at least 12 weeks between doses) **(SJ3/114 - INQ000112227), (SJ3/115 - INQ000112226), (SJ3/113 - INQ000257287).** In particular, the JCVI stressed that any vaccination should not displace the delivery of other paediatric vaccinations (whether non Covid or Covid 19 for those in clinical risk groups).

117. Further, delivery of paediatric non Covid 19 programmes should be given "due attention" in particular where vaccine coverage had fallen behind due to Covid and where there are health inequalities in the uptake of vaccinations. I was clear that I did not want vaccinations which would prevent serious ill health in large numbers of children or which would protect them in their adulthood to be displaced for the Covid 19 vaccination, and so the roll out of the programme was run alongside, rather than instead of the childhood immunisation programme already in operation.

118. At that time, the JCVI considered this to be a one-off response. I agreed with this advice. I looked particularly carefully at the advice on the safety of the vaccine, both from the MHRA and from the US, and also examined the timing and benefits of vaccination of any future way of infection. It was recognised by the JCVI that most children aged 5-11 had very mild infection with Covid and were at extremely low risk of developing severe Covid 19 disease, and that the vast majority of those aged 5-11 would have had infection from Covid by the end of January 2022. I also took account of the advice that the JCVI gave about the fact that the benefits of vaccination in preventing school vaccinations were indeterminate.

119. Alongside the JCVI advice, I received advice from the Department and the relevant additional documents which accompanied policy advice – in this case in respect of the family test and inequalities **(SJ3/116 - INQ000112228), (SJ3/117 - INQ000112229), (SJ3/118 - INQ000112225).**

120. Alongside this advice, the Department, at my instruction commissioned a "business case" for offering the vaccine to those aged 5-11 which was produced in March 2022 **(SJ3/119 - INQ000497215).** Given that the evidence to offer vaccination was not absolute and the benefits to education in future waves was indeterminate, along with the additional costs, time and care needed to administer to this age group in comparison to older children, I felt it important to examine the wider benefits. The "business case" identified the following:

a. It would lead to reduced paediatric intensive care admission, hospital admissions and paediatric multisystem syndrome cases (which were a rare but serious side effect of small children having Covid 19).

b. It would reduce impact and infections for contacts of children aged 5-11, particularly where household contacts were at risk or immunosuppressed (there were estimated to be at least 500,000 people who were immunosuppressed) Reduce educational disruption for children having to miss school.

c. Reduce anxiety in the vaccinated population and their loved ones.

121. I personally was very reluctant about vaccinations for 5- to 11-year-olds. My view was that this measure had not yet been proven necessary, and unless the medical profession could tell me otherwise, then that was my position. I felt there was as difference between vaccinations for adults and children. I had a child at that time who was 13 years old; if they had been 6 or 7 years old then I would not have vaccinated them. For me the further down the age groups you went, the stronger the justification that was required. I thought at that time that it was wrong for me to recommend something that I would not do myself unless there was a very clear analysis or explanation provided to support it. The Prime Minister, on the other hand, was very keen on the idea – again he referred to the statistics coming out of Portugal and other European countries to support his position.

122. The decision to vaccinate children and young people was based upon the advice given to me by JCVI **(SJ3/113 - INQ000257287)**, and whilst there was a difference of

view between myself and the Prime Minister, both of us followed the advice of JCVI. Ultimate responsibility for making decisions about vaccination lies with the Secretary of State for Health and Social Care, but of course the views of the Prime Minister would be relevant to consideration by any Secretary of State. For further information please see the Module 4 Corporate Statement A at paragraph 250-269.

123. In early April 2022 the vaccination programme for those aged 5-11 started and was rolled out by the NHS. Again, I would stress that this was an "offer", and a national public health campaign was not run. It was run through schools or by children attending vaccination centres. This represented a compromise between my position and that of the Prime Minister.

Vaccine delivery

124. By June 2021, most adults had been offered a first vaccination, and so the focus for my tenure was to ensure increased uptake, public confidence and the deployment of the large-scale booster campaign during the Omicron wave. A significant positive factor in vaccine delivery was that there was not a shortage of vaccinations within the UK which must be seen as a major achievement given the globally limited supply.

125. I have been asked questions about how data was collated and how it was then used. I was not directly involved in these issues, only seeing the fruits of these labours where the daily meetings would track uptake by age, but also by sex, ethnicity and geographic area so that we could have a detailed examination of where further work should take place. I refer the inquiry to the corporate witness statement Module 4 Statement A paragraph 307 and paragraph 308 covers data collection which sets out how such information was collated and analysed in some detail.

126. NHS England was responsible for designing and providing the places and workforce for the delivery of the vaccinations. I had daily meetings – and sometimes meetings twice a day - at which the pace and scale of the delivery was discussed.

127. This involved the NHS vaccine delivery team; I remember in particular Nicky Kanani who was responsible in NHS England for liaison with GP's and pharmacists,

alongside senior officials from the DHSC and UKHSA, in particular Mary Ramsey, the Chief Epidemiologist of the UKHSA who had responsibility for the "Green book".

128. The CMO or DCMO would also often be there and the permanent secretary. There would also be attendance from the vaccine supply team. We had a daily checklist of issues to deal with **(SJ3/7 - INQ000480676).** I would describe these meetings as very thorough. At these meetings there would be discussions, updates, but also decisions could be made in this forum. It was helpful to have all the key individuals with overarching responsibility for the vaccine programme meet together very regularly so that actions could be taken, and decisions made quickly.

129. The meeting was designed to take stock, to discuss any issues or problems and to set out future objectives. To give an example, if it were known that the JCVI was in the process of formulating advice, we would discuss what plans were in place to comply with that advice, how any vaccinations would be rolled out, how it would be distributed, whether further resources were needed.

130. The meetings built upon the Vaccine Uptake plan which has been created before I arrived, and which set out a clear strategy for delivery of the vaccine. We had daily data updates so that we could identify with precision particular areas or particular groups who were not being reached.

131. There were various regulatory and practical steps which had to be undertaken before the vaccination could be rolled out – that included updates to the Green Book and changes to protocols.

132. Alongside the daily meetings with the vaccine delivery team, vaccination would also be discussed with the Prime Minister at the daily meeting he held at 8.30. There were daily figures on uptake of the vaccine, including all boosters which were monitored.

133. When I arrived in office the Prime Minister expressed concerns to me that other European countries were overtaking the UK in vaccine uptake. He was always interested in what more could be done to increase uptake. The interest of the Prime

Minister and his focus upon vaccination as the "way out" of the pandemic crisis meant that the vaccine delivery team was always under a lot of pressure.

134. Vaccinations were available in a variety of different places, not just in vaccination centres. They could be accessed at the GP's, pharmacies and in mobile vaccination centres, particularly in places where uptake was lower. It was my job to oversee the roll out to make sure that everyone could have a vaccination if they wanted one.

135. The other crucial part of the roll out was the approach to exhort everyone to get the vaccine without compulsion. It was my job, along with others, to encourage people to come forward. I consider that the public communications about vaccination were of vital importance. Communications were a cross government activity involving not just the DHSC, but also the UKHSA, BEIS, the Cabinet Office and NHSE, alongside local authorities and civil society groups. There was a unified communication plan across Whitehall. Clara Swinson in Module 4 Statement C section 1 paragrah 12 – 54 sets out in some detail how the communication plan worked. I consider that it was not one communication strategy which was effective, but the combination of various strategies.

136. I considered that the provision of detailed information about the science, which demonstrated that having the vaccination avoided serious illness or death, was essential. It was exceptionally helpful that we had the Chief Medical Officers, officials from NHS England and the UKHSA who were able to communicate complex science to the public. It is much better that scientific information comes from those who understand it, rather than from politicians. The provision of weekly Covid vaccine surveillance reports, provision of data, issue of scientific data, publishing advice given to governments by expert groups was all, in my view, helpful.

137. I would also say that the roll out worked because of the enthusiasm of volunteer vaccinators to come forward to run vaccination centres, and the ability at a local level for local authorities and public health officials to be able to access and reach everyone, including those from inclusion health and hard to reach groups for health generally.

138. My role in supporting the vaccine delivery was, at least in part, to appear in the media and to help drive the campaigns being run at that time. I should identify that any messages I delivered were reviewed by the DCMO or CMO for accuracy so that I did

not promote inaccuracies. From July – September 2021 there was a "vaccines: don't miss out campaign" alongside work from the Cabinet office about testing, ventilation and face coverings from September – November 2021 **(SJ3/120 - INQ000480678).** Once Omicron had started, the Government ran a major media campaign by way of the "Get Boosted Now" campaign, (Module 4, Statement C paragrah 43 (d)). This included individual text messages for boosters.

139. During that period, I spent a lot of time either appearing in front of the media to promote the campaign or visiting vaccination centres and other places for vaccination to reinforce the message. My diary for that time shows, for example, **(SJ3/121 - INQ000480683), (SJ3/122 - INQ000480684)**. I would indicate that I would have spoken with the NHS communications team at least every couple of days during my time in office.

Omicron and vaccine delivery

140. I would particularly stress the tremendous work that took place from late November 2021 through to March 2022 to seek to roll out booster vaccinations much faster than had originally been intended because of the Omicron variant. It required dramatic changes in the provision of the vaccine, including alteration of the services that GP's could provide so that those in care homes, in supported living or who were unable to leave their homes by having GP's visit their homes to vaccinate them. That did require me to make a statement in Parliament which asked people not to visit their GP's unless it was an emergency because of the immediate threat to those who were more vulnerable.

141. I would note, however, that the BMA and I did not agree on whether or not undertaking this work should be accompanied by additional payments. GP's had some routine work they would usually do under their GP contracts reduced or removed to undertake the vaccination programme during 2020 and into 2021. When the Omicron variant hit, contract variations were not in place. The BMA wanted additional monies for this work. In my view they were not doing additional work, simply reprioritising their time and so additional payment should not be made. They insisted that additional payments of around £15 per shot should be made **(SJ3/123 - INQ000489917).** I consider the BMA/GP Leadership to not have acted in the national interest during the

Omicron crisis. This is not a reflection of individual hardworking GP's, but the BMA/GP Leadership.

142. Because it was imperative that those individuals received a vaccination quickly, I agreed to the additional payments, but I considered it to be a waste of money. I had made it clear that I did not expect these vaccinations to be additional to the work that they already did. I had told the BMA that I would go to Parliament to make a statement that people should not visit their GP's, which would mean GP's would not have to do their usual jobs in surgeries and could instead go out and vaccinate I also found it disappointing to see that their attitude was to seek to withhold services from those most vulnerable such as the elderly in care homes and the housebound. I felt very strongly at that time that the BMA was taking commercial advantage – by effect being paid twice – in a time of national emergency and was putting the interests of its members above delivering the vaccination scheme.

143. Because of the threat of Omicron, specific steps had to be taken from late November 2021 to ensure that all relevant places could operate extended hours and at full capacity so that the boosters could be administered. This involved making sure that pharmacists could administer the vaccine, expansions of vaccination centres and opening times (including on Christmas day). We vaccinated **(SJ3/124 - INQ000480696)** 38 million people in a six-week period. The period required much energy to make sure that there could be maximum throughput, in as many venues as possible.

144. There was no problem with the availability of vaccines to be used for the booster campaign, thanks to the work of the Vaccines Taskforce (known as VTF). They were present on the daily vaccine delivery calls and I had dedicated meetings twice a week with Maddy McTernan and her team running this task force, largely on supply. This involved examining and keeping abreast of the effectiveness of the vaccines that we had and undertaking adequate research and feedback as to their efficacy against new strains, whilst also ensuring that vaccines could work against more than one variant at once by working with the companies supplying those vaccines.

145. I would say that they did an exceptional job, which should be recognised by the Inquiry. We never ran out of vaccines, and in fact were in a position to give about 100

million doses to other countries as part of our commitments to vaccinating not just our population, but other countries who found it more difficult to get access to the vaccine. I would identify that we worked well with a range of global partners in 20 countries to enter reciprocal arrangements in respect of approximately 50 million items of stock.

146. We also helped Australia by undertaking an innovative vaccine swap; that was coordinated at the political level. They had a shortage of Pfizer vaccine, but we did not. We therefore let Pfizer deliver some of our stock to them 4 million doses **(SJ3/125 - INQ000480661)** (there had been backlogs by Pfizer in manufacturing the vaccines at this point) on the understanding their future supply would come to us. We also did a swap with South Korea where we gave them some vaccines which would shortly run out of their shelf life which they needed immediately and in return we received some of their vaccines at a later point **(SJ3/126 - INQ000480667).** These swap programmes were successful. In the case of the Australian swap, our Pfizer deliveries arrived at a critical time in the pandemic and the public's confidence in the vaccines. I was told by my Australian counterparts that it likely brought forward the easing of strict lockdown measures by around three months. While this was not widely known about in the UK, this was a significant achievement for a close ally that I was proud to have spearheaded and coordinated at the political level – with the Australian High Commissioner to the UK and my Chief of Staff playing key roles in driving it through.

Vaccine delivery across the Four nations

147. I am asked about the differences in vaccine delivery across the four nations. I have outlined above my weekly meetings with Ministers and that we sought to operate a co-ordinated vaccine delivery scheme, with the same public health messages. The weekly meeting of Ministers did discuss the delivery of the vaccine, including the relevant data so we could compare uptake. We also discussed best practice, what had worked, and also how to encourage those groups with much lower uptake of the vaccine and dealing with inclusion health groups. I certainly remember seeking to learn lessons from the Scottish roll out of the vaccination for 12 – 17-year-olds, which we then adopted (by using vaccine centres alongside schools).

148. I would suggest that the four nations showed a high level of collaboration, co-operation and sharing of information to act as consistently as possible. I also know

that the Chief Medical Officers of all four nations met regularly and would have discussed the vaccine delivery programme. The UK government would send the communications that it proposed to publish about decisions around vaccinations following JCVI advice to all four nations, both to the public and to Parliament so that they could see it and had a chance to consider it before it was published. I hope (and think) that they appreciated that I showed that openness to them.

Inequalities, vaccine uptake and vaccine delivery

149. During my time as Secretary of State, the vaccine roll out programme sought to ensure that marginalized and vulnerable communities were as protected as the rest of the population, and searched for ways to ensure that vaccination could reach them, and they would be confident to accept them. The third corporate witness statement of Clara Swinson for this Module Statement C at Section 2 at paragraph 105 - 115 sets out in some detail the work that the Department, along with others, undertook to reduce disparities in vaccine uptake.

150. The inquiry has asked me to comment upon the roll out as it relates to particular groups. That information is covered in detail in the corporate witness statements. I was clear that "inclusion health groups", those from minority communities, those with uncertain immigration status, vulnerabilities by way of disabilities or age, pregnancy and those without a home should all have equal priority and access to the vaccine. I am aware that the Department worked alongside other organisations to ensure that this was the case. I was involved, for example, in speaking directly to the British Asian and Muslim community to try and improve uptake.

151. Dealing with health disparities was something I made a central priority as Secretary of State for Health. An Office of Health Promotion (OHP) was being set up when I came into office, which I decided to rename and reframe as the Office for Health Improvement and Disparities to bring more institutional focus to this challenge. I sought to introduce a White Paper on Health Inequalities (which I understand has been disclosed via the witness statement of Jonathan Marron which shows my commitment to reducing health inequalities and my view that it should be a central focus of government decision making. I was disappointed when my successor did not publish it. I also commissioned the review into medical devices (undertaken by Dame Margaret

Whitehead) which has just been published by the Department **(SJ3/127 - INQ000438237)**.

152. I am asked about the draft White Paper which came into being whilst I was Secretary of State (but was not then published after I resigned in 2022) and whether any parts of the white paper specifically relate to vaccination uptake amongst groups with historically lower rates of vaccine uptake **(SJ3/128 - INQ000468609)**. One of the aims of the White Paper to improve public health was to modernise vaccination programmes by improving how individuals can access vaccination data and book vaccinations, part of which was to promote high uptake and tackle gaps in coverage (paragraph 31, p10/118 of the White Paper Chapter 7 of that White Paper speaks about trying to improve health and disparities outcomes generally at a local level including additional monies for those areas where the health disparities were greatest (paragraph 202, p75/118 of the White Paper). Chapter 9 of the White Paper sets out this policy in more detail at paragraphs 227 – 232 of the draft White Paper. This identified the decline in vaccination uptake (not just Covid but all vaccinations) with some underserved communities less likely to access services, which includes geographic, socio economic and variation by ethnicity with lower vaccination uptakes in Black Caribbean, Black African, White Irish and White Polish populations (paragraph 228 of the White Paper).

153. The proposal to was address disparities by tailoring services to the needs of different groups (paragraph 229 of the White Paper) which includes:

a) Using the school age immunisation service to reach children from disadvantaged backgrounds by providing programmes in schools, other community settings, GP practices out of hours.

b) Better data on vaccination uptake and easier booking systems to identify local teams to take targeted action where there are disparities.

c) Having a tailored service meeting the needs of local people through innovations in when people can have a vaccinations.

d) Using vaccination services at a route into wider healthcare interventions.

154. This was because of my interest in oximeters (and other devices) being less able to judge someone's oxygen rate accurately because of the makeup of non-white skin. As detailed in my Module 2 statement paragraph 85, I had discussions about this with the US Health Secretary, who expressed enthusiasm for working together on these issues. My idea was to indicate that no drugs or devices would be purchased in either the US or the UK if they had not had appropriate testing on a range of ethnicities to avoid such problems as were identified, and to seek to encourage clinical trials engaging and reflecting the diversity of our society.

"Some other steps I took whilst I was Health Secretary was to commission a review about inequalities in respect of the efficacy of medical equipment on the grounds of race, which was chaired by Professor Dame Margaret Whitehead [SJ/66: INQ000309485, SJ/67: INQ000309486, SJ/68: INQ000309507, SJ/69: INQ000309508, SJ/70: INQ000309511, SJ/71: INQ000309512, SJ/72: INQ000309517, SJ/73: INQ000309519, SJ/74: INQ000309518, SJ/75: INQ000309520; SJ176: INQ000309465]. This consultation ran between August 2022 and October 2022, and I understand the panel of the independent review were to provide advice to the government by June 2023. I had read that pulse oximeters gave incorrect readings on darker skin and asked about why this was the case. I found out that this was because such oximeters were tested upon white skin because they are seen as the biggest global market by the manufacturers of such equipment. I talked about this publicly, which helped to raise awareness of these issues within the NHS. The main policy proposal that I thought of to tackle this was that if the US and the UK – who are the two biggest purchasers of medical equipment in the world insisted that it would only purchase products which had been tested in all races, then global manufacturers would do so. I discussed these matters with my US counterpart, but it did not come to fruition because I resigned as Health Secretary. I still consider that the UK should consider making this a requirement of procurement of medical equipment."

155. I would urge governments of any complexion to continue to see the reduction of health disparities as a cross government priority, recognising that a healthier society is not just morally desirable, but is also more economically productive. Less public

spending is needed on health services and ancillary care services if the population are healthier and such a population is more able to deal with any future pandemics.

156. As far as my role is concerned, I was heavily involved in public communications for people with Black African, Black Afro-Caribbean and South Asian backgrounds. The Department had a specific communications policy which dealt with these issues. For those within the South Asian community, I was able to use myself as an example, and I felt that my background was helpful in enabling me to communicate with a community I felt I understood. I spoke in mosques and talked to the Muslim community about the importance of vaccinations, particularly given that some vaccinations do have a porcine content. The concern about porcine content was also explained to the Jewish community who had the same concerns. The Covid vaccination is not one of them **(SJ3/129 - INQ000480647).**

157. Vaccination took place during Ramadan, and so I specifically asked that advice was given to Muslim communities which answered a common question which would be posed which was whether having a vaccination would be considered to break the fast in place during that time. There were also comprehensive campaigns produced in a number of foreign languages both in writing and through diverse communication – including local language radio and TV, and social media, for pregnant and breastfeeding women where the advice changed during the course of the pandemic.

158. As to other inclusion health groups, I remember having a number of meetings about reaching out to people with more challenging needs. In the meeting **(SJ3/130 - INQ000480654)** it was discussed about how the Department was working to ensure that the homeless had vaccinations, through work with charities and local councils who were closer to understanding how to reach these individuals. Vaccination material was available in a variety of different languages, and communications were also delivered in multiple languages. This was not just written communication but also information via television, radio and social media. It included major languages spoken in this country including Bengali, Chinese, Tagalog, Gujarati, Hindi, Mirpur, Punjabi and Urdu (amongst others). This included information available at vaccination centres and via community locations.

159. Alongside this I also reached an agreement with the Home Office that there should be no impediment to vaccination irrespective of immigration status.

160. I am aware that the DHSC worked with local authorities, the Home Office (who provide accommodation for some asylum seekers) and charities working in this area to identify that there would be no immigration checks or any oversight if they came to be vaccinated. I also checked with delivery centres when I visited to make sure that when anyone came in, they would not be asked any questions other than clinical, and the jab should be given to them.

161. I made it absolutely clear that I did not expect anyone's immigration status to be mentioned, or whether they had a home and asked the team at the DHSC and public health officials to communicate this to refugee centres and charities. I felt particularly strongly about this because of my experience during the Grenfell Tower disaster. I was Secretary of State for Housing, Communities and Local Government (as it then was) and we quickly became aware of a number of individuals living within the Tower or caught up in the disaster who had irregular migration status.

162. I went to the Home Office at that time to ask for an amnesty for anyone involved in Grenfell in such a position so that any information they provided to public services about their status would not be used by them or by the police. That was then disseminated to those affected. I felt that the same reassurance was needed, in this case in the interest of public health. I remember an official asking me if my stance meant that if someone came to the UK for a holiday they could come and get vaccinated: I answered that I considered that a price worth paying to ensure suitable immunity for those in the UK. Covid does not discriminate on the basis of status, and neither should a government do so.

163. I understood that those in Home Office accommodation were offered a vaccine via a home office programme. Prisoners were offered vaccines via the NHS services that operate in every prison, and there was a programme for that to take place.

164. These issues on disparity on uptake and reaching inclusion health groups were discussed in the daily vaccine briefing meetings. I remember Dr Nikki Kanani, along

with Prerana Issar, the NHS Chief People Officer, leading a dedicated team to support ethnic minority healthcare workers.

Public messaging

165. I have set out in some detail the work I directly did on public messaging during the time I was Secretary of State. In the Corporate Module 4 witness statement, statement C section 1 paragraph 12 - 54 provides very detailed information and I refer the inquiry to that for more specific information as to how the messaging took place. My role was to sign off on the communications strategies operated specifically by the Department, and I had a weekly communications meeting to discuss strategies. I was not directly involved in setting up the community champions scheme but would participate in events to encourage this work to take place.

166. The focus of the public messaging strategy was about challenging complacency, ensuring convenience and giving confidence. The role of the public message was to persuade, not to direct. I received the relevant government communications which set out and provided questions for example about the effectiveness of the vaccines and the work undertaken on data collation about uptake was also extremely helpful.

167. Module 4 Statement C paragraph 133- 169 sets out in some detail how advice was given to those who were pregnant, breastfeeding, children and specific age groups and the evolving nature of that advice and I do not consider that I can add further to that, save to say that it was a deliberate decision by the government not to run a public campaign to vaccinate children. There were no national media campaigns. As I set out above, the campaign on boosters was successful because the uptake was significant in all age groups and because the campaign encouraged people to go and get vaccinated. I have set out above the particular role I may have played in respect of public messaging which was largely through what I said in Parliament, media appearances and policy announcements.

168. I remember one particular incident in November 2021 where I was visiting St. Thomas hospital and I did an interview with a reporter Jon Craig for Sky News. I asked him whether he had a booster and he said no. I then took him to the vaccination centre myself and we then filmed him having his booster and discussing this with me. The

clip became "viral" and I think it helped demystify for some people the fear of vaccination and show how straightforward it was **(SJ3/131 - INQ000480682).**

Vaccine hesitancy

169. I have been asked a series of questions about vaccine hesitancy and my understanding and experience of it, as well as the steps I took to try and overcome such hesitancy. The work undertaken on this goes far beyond me and was something which was worked on throughout the pandemics by all those involved in the Covid 19 vaccination delivery and roll out. The corporate witness statement for Module 4 witness statement Module C at paragraphs 68- 72 sets out in some detail the meaning of vaccine hesitancy as defined by the Office for National Statistics ("ONS") and the steps taken to try and overcome such hesitancy.

170. I was aware when I came into office that there was lower take up of the vaccine amongst those under the age of 50, with larger numbers the younger the age group. Uptake was also low amongst those who were unemployed or in elementary occupations. There was a link between deprivation and vaccine take up or hesitancy (as set out at paragraphs 56 and 57 of Corporate Statement for Module 4 Corporate statement C). The Government ran a campaign around the time I came into office called "Don't miss out" (paragraph 26 of Module 4 Statement C) which was expressly aimed to support vaccine uptake in young people. I was not directly involved in the community champions scheme and cannot comment upon it save to identify that I met some of them during visits.

171. I was also more than aware of the inequalities shown up so clearly by the pandemic in those from South Asian communities and Afro Caribbean groups who had higher rates of death and hospitalization than other communities **(SJ3/132 - INQ000480649)** I had followed the work published by Public Health England (PHE) on this issue **(SJ3/133 - INQ000399820).**

172. Alongside this, I was generally aware that the vaccine uptake was lower amongst minority ethnic groups than it was for those who were white. The corporate witness statement, module 4 statement C at paragraphs 56 – 62 sets out in some detail the

analysis undertaken by the Department and other government bodies to understand both who was hesitant and why they were hesitant.

173. The JCVI had published a statement in February 2021 about phase 2 of the vaccination programmes which sought to address this hesitancy by promotion of the vaccine to those who are male, those from an ethnic minority background, those with a BMI of 30 or more and those in areas of high social economic deprivation **(SJ3/134 - INQ000480651)**. By the time I arrived at the Department they were working on this issue and the Battleplan (which was the central document the Department had which guided its Covid 19 work) has a workstream which was focused upon protecting those who were disproportionately affected by Covid (7B) **(SJ3/135 - INQ000480648).** This included following the JCVI advice and that of the CMO that an important factor to reduce disparities in outcome from Covid 19 was to ensure good vaccine coverage.

Your understanding of levels of public confidence or mistrust in Covid-19 vaccines

174. My knowledge of public confidence or mistrust in Covid 19 vaccines was informed by the information gathered by the policy teams within the DHSC, the communications analysis and surveys undertaken, my conversations with the UKHSA and the DCMO and the CMO, NHSE and the information I received from JCVI and others. I was informed by the briefings I received which synthesized that information and from the daily meetings where we discussed vaccine uptake, and thus public confidence.

175. I considered it essential to seek to encourage maximum public confidence in the vaccine and to seek to provide factually accurate scientific information in a comprehensive manner, via the CMO and DCMO and other experts in public health. To that end, any public statement I made about vaccine uptake or vaccination which involved discussion of the science was checked with the CMO office, UKHSA or other appropriate clinicians so that it did not convey misinformation or inaccurate facts.

176. My role in this was to:

a. oversee and make sure that steps were being taken to tackle disinformation and

b. understand why people felt this way and

c. assist those working on this to provide support, usually by way of media interviews and the work I did in Parliament, to assist in the uptake.

177. I would receive a synthesis of the research and information collated by others as set out in the DHSC corporate witness statement.

178. In particular, I would undertake media interviews and visits to vaccination centres, and also use the platform I had to seek to assist in reaching those "hard to reach groups" but also ensuring that such groups felt represented in the messaging that was being set out **(SJ3/136 - INQ000480687).** The corporate statement Module 4 Statement C, paragraph 105 – 115 sets out how trusted members of various communities, alongside those who were familiar to the public, played a valuable role in dispelling hesitancy. We also worked with religious groups and other community groups. There was not one particular thing I can point to which helped dispel hesitancy, but an accumulation of factual information delivered by a variety of forums on a regular basis.

179. All the political parties were supportive of vaccinations and that there was political consensus. I consider that this was helpful in ensuring take up of the vaccine and in securing a broad view in society that vaccination was a positive step. I always consulted the opposition to inform them in advice of decisions around vaccinations. I look at other countries where there were political divides evident in whether vaccination should take place (for example in the United States) and you can see that this may well have played into vaccine hesitancy. We did not have this in this country which I am confident assisted in vaccine take up with surveys ranking the British public at the time as one of if not the most pro-vaccine populations in the world.

180. The corporate statement at Module 4 Statement C paragraph 105 - 115 sets out in some detail the ways in which the DHSC sought to gather evidence on the causes of mistrust. I remember seeing attitudinal surveys and commissioning them from the NHS to identify why people were hesitant.

181. For those who were hesitant, we used celebrities to try and encourage use of the vaccine. Sometimes that did not work. I asked my officials about the prospect of the England football team doing a clip about vaccination. I understand that the communications team explored this idea but were told that several of the players had not been vaccinated so we had to just have the captain – Harry Kane – which was great, but not as good as all of them undertaking media promotion to have the vaccine.

182. Whilst there were some who were vaccine hesitant, I consider that there was a remarkably high degree of political and societal consensus around the vaccination. The party-political consensus meant that there was a single message being spoken by politicians of all hues (with a very small number of MP's who were sceptical). There was also good trust in the MHRA as an independent medical regulator alongside JCVI, made up of experts who are not part of the government. I considered that the independence of these panels, and the fact that they had existed for a significant period of time before the pandemic did lead to greater trust and confidence in their decisions.

183. I also consider that the public put their trust in those scientists who regularly appeared in the media (such as the CMO, the Deputy CMO's) and having them speak was an important part of creating public confidence. I consider that the public trusted these individuals and saw them as experts.

184. This can be contrasted to other countries who did not use clinical experts to assist with public messaging or where clinicians would not engage in this way. I remember those from other countries speaking to me about our use of medical experts and their messaging and how remarkable they considered it was. My experience was that most of the population recognised that it was a national crisis and that vaccinations would help to get our society from having to lockdown and they would have the vaccination on that basis, and listened to those experts and trusted them.

185. There were few people I came across who would not take the vaccine, rather than being hesitant about taking it. I remember one occasion where I was visiting an intensive care ward (where 27 or the 28 individuals there had not been vaccinated) and the doctor stated that he would not be vaccinated and he did not believe in them. This was on national television. He indicated to me that he would rather that everyone

else became vaccinated than him, and he does not need to have it because others would. His claims were both clinically and scientifically wrong but also damaging to public confidence, which was regarded as deeply irresponsible by the medical community.

186. My understanding was that majority of those who did not take the vaccine were younger and fitter who felt that they would not become as unwell if they contracted Covid. Furthermore, a large number of young people had already had Covid by the time that they came to be vaccinated and so considered that they did not need it as they had antibodies present in the body. There were some conspiracy theories, such as it would make you sterile, which had to be confronted. As the Secretary of State, I asked that the Department looked at all these causes of hesitancy and look as to whether we had a plan for this, whether it was working, and what other countries were doing. We did consider providing financial or other incentives for vaccination of those in younger age groups; some other countries had trialled providing monies or gifts for vaccinations, but we considered that was not likely to work effectively at increasing confidence. I wanted people to choose to get vaccinated for their own health and that of others, not because they were induced by a financial incentive. As is identified in the third witness statement of Clara Swinson for this Module, one can see that there were plans in place to address hesitancy throughout the pandemic and that work was undertaken to examine what worked and what did not. I consider that Ms. Swinson's witness statement provides a level of detail about this.

187. As to measures that can be taken in any future pandemic, I would advise continuing with a procedure for approval of vaccinations that is independent of political interference and is independent and clinically based. I consider that it essential to maintain public trust.

188. I also considered that if you are employed by the state, for example working in the NHS on a front-line clinical role and you say something which is contrary to the medical or clinical advice issued by the regulators and which has no foundation in legitimate clinical difference of view then steps can or should be taken.

189. The UK has historically never mandated any vaccination on a population wide level though there are some vaccinations which clinicians working in contact with patients

have to take, for example Hepatitis B. This is unlike several other countries in Europe where vaccinations are mandatory. I do think that in any future pandemic, if a vaccine is developed, thought should be given to whether vaccination should be mandatory for health professions and social care staff working directly with patients.

190. I am asked why I said in my module 2 statements that "*other European countries had more difficulties than the UK did convincing their populations to have booster vaccines or vaccines in the first place*". I was aware of this both through work the UK government did to understand the position in other countries but also in my discussion with other health Ministers. I do consider that our strong political consensus, having an approach which sought to place independent and impartial clinical advice at the front and centre of the vaccination campaign and providing detailed information to those receiving the vaccine were all very helpful for our country.

191. I have already indicated that some minority groups have historically felt discriminated against when they use healthcare in this country and also felt excluded from healthcare. Trust is bred at least in part, by using doctors, politicians, experts who reflect ethnic diversity and have understanding of the reasons why there has been hesitancy. The NHS is a very diverse workforce and we used those diverse experts to help get the message across. I also consider it is important to acknowledge that people were historically mistreated, and not try and pretend that this hesitancy did not have some roots in the past. That is why I commissioned the Whitehead Review into discrimination in medical devices and we made those terms of reference public so that those from ethnic minorities could see that the DHSC was taking these issues seriously.

192. I also sought through the development of the White Paper on health inequalities to work further on health outcomes of those form different ethnic minority groups and to have discussions around improving outcomes and treatment. I remember having discussions with the CMO on an informal basis where he would indicate that these issues were important and that something needed to be done about these issues.

193. It is also important (as set out above) to ensure that communications campaigns were not just focussed upon the mainstream but were engaged with and provided messages to the internal eco systems of some communities. I spoke with Dame Louise

Casey (who had written reports on social cohesion in December 2016 **(SJ3/137 - INQ000480646)** and who had identified that there were 2 million people in the UK who do not speak English fluently. Some of these people, for example some parts of the Bangladeshi and Pakistani community, in particular women, were not engaged with broader society and so we had to find bridges to those women. We would have mobile units in places where they may go (such as shopping centres) and try and encourage individual conversations through local engagement at a micro level.

194. I was also told on a number of occasions that younger members of those from Bangladeshi and Pakistani background were becoming vaccinated but did not want others in their community to know, because, for example, their parents were opposed to vaccination. I consider that it is important to stress that medical information is private, and that in any future vaccination campaign to reassure young people that their vaccination status is confidential to them.

195. I wanted the Office for Health Disparities to be set up and commissioned a White Paper on Health disparities because I wanted to encourage more research on discrimination in medicine and to do positive work to try and improve this. I also think that the work that the DHSC does (along with the NIHR and other bodies) in funding and undertaking work on international health around the world also helps to provide research, information on diseases or illnesses which are particularly prevalent in certain communities. For example, government funding of a joint project between Manchester and Kenya university on research into skin cancer which only affects those of African heritage **(SJ3/138 - INQ000480711)**. I consider that the UK government financing research like this helps build trust in the health system in this country by showing that all forms of disease are the subject of interest and research. I also consider that our work doing on international health treaties and regulations is also helpful in demonstrating that we as a government care about health outcomes around the world.

196. I also pushed at the WHO and G20 meeting in Italy and the G7 in Germany about broadening clinical trials to include all ethnicities. I am aware that the volunteers that come forward for such tests are often of white heritage, and more efforts need to be made by governments, drug companies and the WHO to ensure that medical trials are racially and ethnically diverse.

197. I do think that "behavioural analysis and understanding" would be helpful to any future pandemic decision making where there is a necessity for vaccination or administration of any other form of drugs so that the root causes of hesitation or anxiety can be addressed in "peacetime." I also consider that more behavioural science work on incentives to vaccination would have been useful in seeking to devise "nudges" so that there was greater take up. Further expertise and advice were needed about ensuring better take up from those from ethnic minorities. We knew that black citizens, particularly men, had lower take up rates than others. Again, the way I set up OHID was to provide a place within the DHSC where this work would take place as a matter of routine.

198. I am asked about whether or not I had access to the learning of the Cabinet Office behavioural science consultancy and specialist agencies. The answer to that was yes, as the DHSC would have had access to this information which would then have been fed to me via ministerial submissions where relevant. It was not my role to analyse or assess this particular work of these teams, as they would have been the "building blocks" for designing campaigns in particular ways. I have no particular comments as to how such work could have been improved as I am not a behavioural science specialist. My opinion would be that the team in the Cabinet Office was relatively small, and that I would advise that such behavioural science team should be embedded in the design of health communications outside pandemic periods and should be resourced sufficiently to provide adequate advice to governments on health policies.

Vaccine as a Condition of Deployment ("VCOD")

199. Vaccination as a condition of deployment in respect of care homes was a policy in place when I arrived as Secretary of State for Health. A consultation response on the proposals issued by the DHSC had been issued on 22 June 2021 and the Regulations were placed before parliament on the same day, with the regulations being brought into force in November 2021 **(SJ3/139 - INQ000480695)**. In my meetings with the Prime Minister, he saw this as a priority. From the start of my time in office he asked me to look at having this policy within the NHS alongside care homes.

200. This policy did have some challenges when presented to Parliament, with a number of conservative MP's not wanting to vote for what they saw as mandatory restrictions. I did not see it in that way. I considered that it was important that those who worked with the vulnerable should minimize the risk of those individuals catching Covid 19 by being vaccinated. Many people were understandably concerned about elderly loved ones being put in the position of undue potential exposure. Regular testing was considered as an alternative but that was not sufficient to stop outbreaks happening in care homes.

201. I was also aware that the sector claimed both publicly and privately that the workforce problem would be acute because large numbers of individuals would refuse to have the vaccine. There were significant individuals who took to the media regularly with catastrophic predictions for the sector, such as Ms. Ahmad from the Association of Care Homes. I considered that these claims were not based upon credible analysis, and I consider that although some individuals did leave the workforce, it was nowhere near as many as had been identified or indicated.

202. The Director General for social care (Michelle Dyson) reassured me that their team called every local authority weekly and ask them to provide us with details of problems with take up in care homes and they were not seeing the problems stated in the media. When I met Ms. Ahmad at an event she indicated that she wanted to use this policy to try and get more money from the sector. Her approach was both unprofessional and was a disservice to those within the social care sector who had already sacrificed a lot to care for those they looked after.

203. At the time I came into office, the policy only applied to those in social care. I do not know why the two bodies of health and social care were not seen as a whole for the policy of VCOD as I was not in office when the policy was first developed. I assume that it was because the take up was higher in the NHS, but I am not sure. I consider that in the future, health and social care should be looked at in tandem for issues like this.

204. The take up of vaccination within the NHS was much faster than for those in social care and so the concern about unvaccinated staff was less acute. I think that as the NHS is a centralised state body it was easier for staff to get vaccinations and for hesitation to be addressed. I asked NHS England for their advice as to whether mandating the vaccine was a positive thing, and they indicated that they agreed with it. I knew that the policy would face opposition, but with NHS support I considered it was a policy we should introduce. We had a consultation about extending the regulations on **(SJ3/140 - INQ000480664),** to which we had a response on **(SJ3/141 - INQ000257101)**. The relevant regulations were laid before Parliament on **(SJ3/142 - INQ000480645)** and there was a debate in Parliament on about the measures. The regulations were due to come into force in April 2022.

205. As to the impact of VCOD I would not say that it fed into vaccine hesitancy. People were hesitant before this policy came into force and afterwards. I do recognise that in a sector which has a high proportion of staff from minority backgrounds that the level of take up was lower amongst a subset of the workforce. That was reflective of general issues to do with vaccine hesitancy and not the policy as set out.

206. I did consider whether what I was doing was right in implementing this policy but did not consider it ethical to drop a policy which would assist vulnerable people because of vaccine hesitancy. I considered that the policy had to be colour blind, as the impact upon individuals who had Covid and were from certain minority groups was, as the inquiry is well aware, sometimes more severe because of various factors such as co-morbidities, multi-generational housing, occupation and poverty. I did however recognise that to try and address vaccine hesitancy it was important to put even more effort in respect of communications, clinical messaging and creating confidence **(SJ3/143 - INQ000480656)**.

207. I also strongly disagree with those who said that it was "forcing people to be vaccinated." This was not the policy. If people wanted to work with vulnerable people, then they should have the vaccination. If they did not want to get vaccinated, there were lots of other forms of employment which did not require vaccination and I said this expressly in media interviews. I considered it the same as wearing PPE or taking basic infection control measures. The capacity of our hospitals to function amid the pandemic was a major driver of lockdown restrictions, so I would think anyone who

cared about maximising freedoms would see the case for that even if there is natural discomfort about perceptions of any kind of mandatory health measure.

208. The same concern also arose in respect of vaccine take up for staff in the NHS. I know that there had been work done on NHS staff in some areas (such as Leicester) which showed much lower take up than in other areas which was related to the ethnicity of those working in the NHS. My view was that we needed to have focus, effort and opportunity and resources into those areas with lower take up and into those working in the NHS in those areas where take up was lower. As a proportion within the NHS, I think I remember that there were less than 10% of the workforce who were not vaccinated. I considered that having a policy of mandating was appropriate to encourage those still hesitant to get the vaccine.

209. I consider that the policy did work. I consider that the numbers who left the workforce in social care were much smaller than the sector had anticipated, and those in the NHS were very few indeed. I say this because the data showed that from September 2021 – January 2022, more than 127,000 NHS staff came forward for a vaccine after the policy had been announced and that 95% of all staff had at least one dose by that time, and subsequent to regulations the uptake amongst care home staff rose from 77% to 94.5% **(SJ3/144 - INQ000497214)**. My view is that in any future pandemic, if there is a safe and effective vaccine and it would reduce transmissibility then in the "checklist" of things to do then there should be a requirement to have Vaccine as a condition of deployment in health and social care. This should be the starting presumption, as the very least, and so legislation should be put in place at the start, and it should be factored into planning. This was not something I would have considered prior to this pandemic, but I consider it is a very valuable lesson to learn.

210. I am asked about the process by which the decision was made not to pursue the policy. I was guided by information from the CMO, NHS England, UKHSA which showed significant uptake in vaccination by health and social care staff, as well as the general population by January 2022. The Omicron variant was very transmissible, so that almost one third of Covid 19 cases which were reported happened between the end of November 2021 – end of January 2022. The Omicron variant was less severe, leading to less hospitalisation from having the virus, and UKHSA data showed that having a full primary course of the vaccine no longer provided the longer-term public

health protection against the spread of covid. The process for making the decision was based upon statistical information and data collected by the UKHSA which showed that protection against infection declined quite quickly after a booster, although it did protect against severe disease. This data emerged during December 2021 thus leading to the position being different as to whether vaccination needed to continue to be mandatory.

211. I was provided with advice from officials **(SJ3/145 - INQ000497213)** which then led to the announcement on 31 January 2022 **(SJ3/144 - INQ000497214)**, and then a consultation which was issued on 9 February 2022 **(SJ3/146 - INQ000502384)**. The result of the consultation was set out in the governmental response **(SJ3/147 - INQ000325348)** which identified that the majority of those who responded supported revocation, and as a result of this and the equalities impact analysis decided to revoke the regulations. The policy was decided following the issue of the consultation. I would have been ultimately responsible for authorising the revocation, but it would have been after relevant advice was given to me. I can't remember there being a range of views expressed about revocation as it had emerged from the data information and from the changed position brought about by Omicron.

212. In the future, I would wish those individuals who may require vaccination as a condition of deployment be encouraged to think about it as part of their responsibility as those who serve others. I don't know if VCOD had been mandated from the start of the pandemic whether it would have made any difference to transmission in hospital and care homes, but I consider that this is possible.

213. I would also identify that the United Kingdom was not the only country which introduced VCOD. Other European countries also did so, for example France and Germany (although I do recognise that at least in Germany vaccinations are mandatory before attendance at school so the approach is different).

214. I also consider that in any future pandemic thought needs to be given to other areas where transmission rates were high and were the vulnerable were living or may have high levels of exposure so that VCOD would also apply to those in the sector – the most obvious cases would be where individuals are in the care of the state – so

for example prisons or boarding schools. It would obviously depend upon the nature of the pandemic and the type of transmission, but it should be considered.

215. The policy in respect of the NHS was not brought into force because the vaccine's ability to prevent transmission of the Omicron variant was less than it was for the other variants. Because of this, it was not seen as necessary because having the vaccination protected the person from serious illness but did not prevent the virus being spread by those who had been vaccinated. The purpose of the policy was therefore undermined and so it was not pursued.

Dis/misinformation

216. We would discuss misinformation during the vaccine task force, delivery task force and communications meetings. We examined how we were countering it, what was being seen in other countries and then preparing information in response. There were a number of ways of countering disinformation. The corporate statement Module 4C: paragraph 196 – 212 sets out these issues in some detail and so I simply provide my reflections and views here.

217. One of the mechanisms to counter disinformation was to have clinicians and experts provide information to the public – we would ask, for example, Jonathan Van Tam to give interviews, and to answer questions so provide the fact and the reassurance. As a politician, I am not the best person to communicate scientific fact and expertise.

218. I had personal experience of a significant threat to my family because of those who had believed vaccine disinformation. I was out for dinner and some individuals who considered that the vaccine was "murdering" people knocked on the door of my home, where my daughter (who was under 18 at the time) was present and told her that I murdered children. They wouldn't leave when she asked them to and waited outside for me. The police came and dealt with the person, but it turned out that he had handcuffs and other things which they assessed made him a genuine threat. He had a petition with him saying that I was murdering people **(SJ3/148 - INQ000480705)**. I had police protection whilst Secretary of State for Health (which would not usually be the case and was because I had protection as a former Home Secretary) I consider

that the abuse and threats that the CMO and DCMO received to be extremely serious and potentially deleterious to future recruitment into these roles. No- one –let alone individuals who had selflessly worked around the clock for years to put the health of the nation first – should be the subject of threats.

219. I have noticed that since the pandemic there has been a growing degree of conspiracy theories around vaccination (and potentially more generally). This will make future vaccination campaigns in future pandemics more difficult to implement. Steps need to be taken in non-pandemic times for disinformation to be countered through accurate, straightforward evidence and information.

220. I also consider that there should be reconsideration of who gets security whilst undertaking high profile posts. I would consider, given the high level of abuse and threats that I received as health secretary and assuming that this is the same, that security should be considered as necessary for their own protection and to give them confidence to do their job.

221. There are limits to the ability of any national government to prevent disinformation on its own. Much of it is spread through social media platforms which are global and not in the jurisdiction of the UK. It may be that the Online Safety Act may provide some protection against such matters, but that is yet to be seen. In the case of this pandemic, there were also very high-profile individuals who spread obvious misinformation – for example the President of the United States until January 2021, and it was extremely difficult to manage. You want to maintain diplomatic ties and good relationships with countries, but as health secretary it is also your responsibility to point out obvious untruths or wild theories without any basis in evidence.

222. I was asked about my views of various high-profile people during media interviews and did my best to answer them if I could. For example, Novak Djokovic, the tennis player said he would not take the vaccine as it would hurt his performance **(SJ3/149 - INQ000480692)**. I said in public that I thought he was wrong and that he should reflect on this decision.

223. There were also a tiny minority of MP's in Parliament who used Parliamentary privilege to spread what I considered to be disinformation. I considered they wanted to be given airtime, I felt that engaging with them would simply make the problem larger. As we had such a strong political consensus, their voice was not as strong as it could have been.

224. I consider that a Parliamentary rule could be considered so that if an MP says something which is obviously dis/misinformation during a national health emergency, then there should be an obligation on the Speaker to intervene and state to Parliament that what has been said is contrary to JCVI advice, and any other advice, and should be taken in that light.

225. I do not consider that misinformation should be made a criminal offence or there should be censorship. I think that would just exacerbate the problem. Public broadcasters should be able to identify when matters are plainly incorrect with a health warning, as should other parts of social media and any media platform, but I consider that creating a criminal offence would just be fuelling the view of individuals prone to believe conspiracy theories that there is something to hide. I think that the best way to counter disinformation is with real information.

226. I do consider that those in public office around the world need to be clear that health pandemics should not be used for political gain or exploitation or to foment political division. This did not happen in the UK, as there was strong political consensus, but one can see the experience of the US where the vaccine take up rate correlated in many cases to the voting preferences of that particular state. I would never want a pandemic to be a political "wedge" issues in this country – it should be seen more as a collaborative war effort.

Inequalities

227. I have been asked questions about how existing inequalities impact on access to and uptake on vaccines. I have set out in some detail throughout this witness statement my view on inequalities and so have nothing to add to that. I would point to the corporate witness statement for Module 4C paragraph 116- 132 which provides

significant detail on this issue. As I have already said, I was very focussed upon it, recognised it as a problem and took steps to improve access and uptake.

Safety

228. I was provided with information by way of advice from the CMO office the UKHSA and from officials when the risks associated with vaccination came to their attention. I was told by clinicians that people would react in different ways and like every other drugs, risk existed. I had to weigh this up with the threat the country faced and make decisions.

229. Whether something was safe was a matter for the MHRA. It is and was totally independent of the Department. I did not have any discussions, and neither did any other Ministers with the MHRA about approval of any drugs. I met Dame June Raine, the then Chair of the MHRA only once during my time in office and that was to set a budget for her organisation **(SJ3/150 - INQ000480698)**.

230. I can't remember anyone questioning the independence of the MHRA in Parliament or elsewhere or the JCVI, or the CMO. I don't consider that it was an issue, and that the public, professionals and others were all clear that those undertaking this work had sufficient expertise and independence. I therefore cannot answer the question posed about the evaluation of levels of public confidence in the MHRA, as no –one ever raised this as a concern with me.

231. I was often asked about the safety of the vaccines. I would respond by repeating what I knew – which is that I could not say that it was definitely 100% safe for everyone but that the MHRA, the JCVI who regulate these issues consider that it is safe and would answer like that.

232. As an aside, I consider that our ability to have large quantities of vaccine delivered speedily was materially assisted by our indemnification of vaccine manufacturers for claims against them for vaccine damage. I consider this was the right thing to do and should be considered in similar circumstances in the future. I have been told (although it is hearsay) that the EU refused to give such an indemnity when they started negotiations with the EU whereas we did so from the start. That helped us to make a

deal earlier and to have the vaccines first no doubt saving lives. I consider that shows that such indemnification was necessary.

233. I did receive advice about the risks of myocarditis to young people and I had a number of discussions about it **(SJ3/151 - INQ000480679)**. My personal view is that there was a risk from myocarditis, but it was very small and not remotely high enough to suggest that young people should not be vaccinated.

234. I also received advice about which type of vaccine to give to those under 40, with a decision being made that they should not receive the AstraZeneca drug. I would also point to the time that the JCVI took to make decisions as to the vaccination of children to their careful consideration of matters. They would not allow speed to get in the way of the risks and costs and clinicians were not willing to sign off for the sake of speed on even a small amount of relative risk despite the wider potential risks at play during a pandemic. There can be a tension between a government who want things roll out as quickly as possible and clinicians who want to wait, for example, 6 months to be 5% more sure.

235. I am asked about the Yellow Card system. This was not something that came to my attention and I cannot answer whether it is effective, and observations about the scheme and how it could be improved.

Vaccine Damage Payment System

236. I did not know that this system existed until I became Health Secretary. MP's raised issues with me in the House of Commons about the payment scheme. I was told by MP's that their constituents had found accessing the scheme to be slow, bureaucratic and cumbersome. Payments were also considered to be inadequate by those that received them. Until fairly recently, the VDPS had been part of the DWP, and I was in office when I agreed that it should be moved to the DHSC. The corporate witness statement at Module 4 Statement C Section 5, paragraph 239 – 271 has more detail than I can provide about the scheme.

237. I did ask about how many people worked at the DWP on the scheme whilst I was in office and was told that the staff numbers were small who worked on this area, and

so when Covid happened they were overwhelmed as they suddenly had significantly more claims and queries than they would usually have and found it difficult to cope with that increase in numbers on a rapid basis. I remember meeting with the Secretary of State for Work and Pensions and agreeing that more staff should be allocated to this.

238. My view is that the whole system is not fit for purpose. It needs a root and branch review, to make it quicker, more accessible, less bureaucratic and more able to meet the needs of those who require it.

Valneva

239. I am asked about the cancellation of the vaccination contract with the pharmaceutical company Valneva, in September 2021. My understanding is that Valneva was one of a number of pharmaceutical contracts with whom we signed contracts in 2020. I remember having clear advice from officials that we did not require this vaccine as we had sufficient supplies, and I also remember that there were some question marks from officials about whether it was clinically effective. We therefore filed a termination notice on 13 September 2021. My decision said that there were commercial reasons why the contract was cancelled, and it would not get approval by the MHRA in the UK. As this statement was made in the House of Commons, I shall not go any further because of parliamentary privilege.

240. There was a factory in Livingstone Scotland which was operated by Valneva and there were concerns expressed by various individuals (both MP's and others) that this could affect the UK's relationship with the bioscience industry. Valneva subsequently moved its production from Scotland to Germany. My view was and had always been that we should try and develop our pharmaceutical and bioscience industry in the UK, and I was very supportive of providing relevant assistance where possible to life science organisations to develop their businesses in the UK. Of course, the Government considered the impact of the contract termination on the readiness of the industry to work with the UK government in the future but it was not possible to justify continuing to spend money on a vaccine which we did not need and was not viewed

as clinically effective by our officials at that time (obviously I cannot state what the current position may be).

241. In my view the lesson to be learnt from this episode is that we had the right approach in agreeing contracts with a number of companies and the companies which signed these agreements were aware of this. The only other option was to continue with the contract which to my mind would not have been an appropriate use of public money.

Vaccine Manufacturing and Innovation Centre (VMIC)

242. I am asked about my view about the impact of the sale upon the UK's ability to develop future vaccines in the face of a future pandemic and upon the sale of VMIC. The VMIC was set up in 2018 with funding from UKRI but also the Engineering and Physical Science Research Council as a joint venture between the University of Oxford, the London School of Hygiene and Tropical Medicine, Imperial College, and industry partners. The goal was to promote, develop and accelerate the growth of the UK vaccine industry. Additional monies were put into the VMIC in 2020, and the physical site opened in 2021. All of this was before my time as Secretary of State. My understanding was that it was always envisaged that this centre would, once up and running, be sold by the government to a private company. I inherited those plans from my predecessors. I considered that it could be more creative, innovative, seek more sources of funding by being transferred to the private sector. I am aware that individuals, including Baroness Bingham, the previous head of the Vaccine Taskforce, identified that vaccine research, development and manufacturing should be part of any national security strategy. The public investment in VMIC was led by the Department for Business, Energy and Industrial Skills and it was they, along with the VMIC board, who made decisions about sale. My view was that if the sale were to stimulate greater innovation, research and development in the UK then it was appropriate to sell the centre. I do not consider that the sale would inhibit our ability to manufacture vaccinations at speed in the face of a future pandemic.

Therapeutics

243. I was not Secretary of State at the start of the pandemic and so had no experience of the stockpiles present prior to Covid 19 and cannot provide any information about

the lessons learned from previous pandemics. As I am not a clinician, I do not consider it appropriate to comment upon those issues.

244. By the time I became Secretary of State, the Antivirals Taskforce had been set up with a goal to identify two effective oral antiviral treatments for Covid 19 and to seek to procure those medicines by the end of 2021. I was also on the VTF Ministerial Panel, which I do not remember meeting very often. The Panel were largely the same group of people that oversaw and were part of the Vaccines and Anti-Viral Task Force. It was a way of making a formal recommendation to procure various therapeutics on a cross-government basis as it involved officials from a number of departments. It was the case that at the meeting in July 2021, it agreed to approve purchasing doses of Sotrovimab which was a monoclonal antibody (see DHSC read out from that date **(SJ3/152 - INQ000408749)**. The Vaccines Taskforce, which is now part of UKHSA, holds all of the VTF ministerial panel papers.

245. I was not involved on a day-to-day basis with the detailed workings of the task force and its expert advisor group but would be briefed by those working on it (in particular Charlotte Taylor, the chair of the programme board and Eddie Gray and officials) about the work of the ATF including implementation, planning, and process.

246. I did receive minutes of the expert operational board meetings **(SJ3/153 - INQ000489912)** but they were not necessarily passed to me given the triage system in place. Lord Bethell, who at the time was the Minister with the relevant portfolio would chair the ATF operations board. I may not necessarily have read all the minutes and papers that I received as my private office determined which of those were my priority on any one day, and I cannot recollect them with the clarity I can about other situations. If I read them, I would have taken a note of the action's steps and key points.

247. I was provided with advice by the ATF on 30 August 2021 about the options to purchase antivirals **(SJ3/154 - INQ000489913)**. Eddie Gray, the Chair of the ATF told me that he wanted to procure 1.8 million courses of molnupiravir and 250,000 courses of Paxlovid with a further 700,000 doses of "Project arrow". This advice was supported by the CMO and the DCMO, and I received further advice about this on 2 September 2021 direct from Eddie Gray **(SJ3/155 - INQ000410523)**.

248. These antivirals would be used for those who either could not tolerate the vaccine or were extremely vulnerable to serious ill health. The policy argument as put to me was that antivirals were an insurance policy: it was not clinically clear that booster vaccinations would work against any new variants, and without them there would be a significant risk that in that situation the medical interventions offered to those in the UK would be significantly less effective without these antivirals in place. I viewed them as a necessary part of the armament to fight Covid and as appropriate insurance – which was the advice that the ATF, the CMO office and the Permanent Secretary to me **(SJ3/156 - INQ000489911)**.

249. On 1 September 2021, I had a phone call with Pfizer to discuss the purchase of Paxlovid. They informed me that they had orders requested from a number of other European nations and the US, and that if there was not an order from the UK swiftly, these would be lost. I was of course very keen to avoid that happening.

250. I did not have the money in the health budget to pay for them, and so the Treasury needed to authorize the additional spending. I was aware that Eddie Gray and the Taskforce were frustrated about the time it was taking for the Treasury to approve this sum of money. I shared that frustration and concern. Along with Eddie Gray, I was trying to unblock this **(SJ3/157 - INQ000489914)**. I was aware of Eddie Gray writing directly to the Prime Minister to encourage urgency in decision making **(SJ3/158 - INQ000410527)** and I was doing the same. The key decision maker at the Treasury was the Chief Secretary to the Treasury, who at that time was Steve Barclay, along with other senior officials. I do not have access to Cabinet Office documents to be able to provide written material about the views of the then Prime Minister.

251. The Treasury were indicating to my officials that they would not fund the antivirals because they were concerned about how efficacious they would be, and about the cost of them. They said that they would fund the trial which was being run – called the Panoramic study – but that was not what I was asking for. I was flummoxed by this response. Treasury officials are not clinicians. The Chief Scientific Adviser and the Chief Medical Officer supported this procurement of these drugs and considered they were appropriate and efficacious. I felt the Treasury was trying to impose their views

about the science and this was (a) inappropriate and (b) could well mean that we were unable to buy any antiviral drugs.

252. I raised my concern at the Treasury reluctance to pay for these drugs informally with the chief of staff for the Prime Minister, Dan Rosenfeld, who was trying to broker a deal.

253. Eventually, the Department agreed to terms with the Treasury, not for as much money as I had asked for on 26 September 2021. We had missed the deadline. However, set by the pharmaceutical companies and were given 480,000 doses of molnupiravir (known in the ATF as "Project Arrow"), and were given only 780,000 doses in total. The Treasury had to be dragged through this process, which took far longer than it should have.

254. I am asked about the innovations introduced to accelerate the development of Covid 19 and any obstacles to the rapid development of those therapeutics. The corporate witness statement Module 4 statement B sets out the innovations and I have nothing to add to this. As to any obstacles, the only ones I've encountered related to funding, and nothing else.

255. I was told on 8 October 2021 that the team sought to procure 480,000 courses of molunpiravir and 250,000 course of Paxlovid **(SJ3/159 - INQ000489915).** As part of this, I was asked to decide whether to reduce the contractual requirement of the shelf life of molunpiravir (Project Arrow) from 14 to 12 months. Usually, the drugs procured for the NHS had to have a shelf life of 14 months **(SJ3/160 - INQ000480671)**. I agreed that this should happen as I considered that the likely usage would be over the winter of 2021/2022 (paragraph 27.26 of Witness Statement of Eddie Gray). The contracts were signed for Project Arrow on 13 October and for Project Tyne on 18 October.

256. As soon as the Omicron variant was identified (I was told about it on 24 November 2021) **(SJ3/161 - INQ000480680), (SJ3/162 - INQ000257119),** I asked the ATF to procure further stocks of the antivirals set out above b because of the emergence of Omicron on 26 November 2021 **(SJ3/163 - INQ000346546).** Again, there was the same problem as in September with the Treasury being unwilling to provide the

additional sums. I exhibit here WhatsApp messages between the Dan Rosenfeld, then the PM's Chief of Staff, myself and the Prime Minister where I express my frustration about other countries placing orders before us in respect of antivirals **(SJ3/164 - INQ000236362)** and that in a what's app on 8 December 2021 I said:

> *"We have been far too slow and are moving to the back of the queue as each hour passes, meaning we may get v little for winter.*
> *Our proposal has been sitting with HMT for 2 weeks (!) and we have nothing. We have answered every possible question, but we are still just wasting time as other countries beat us to it. We do not have enough for what is about to happen."*

257. Eddie Gray expressed his frustration with me about this on 1 December 2021 **(SJ3/165 - INQ000309476)**. Again, I had to speak with Dan Rosenfeld and with the Treasury to get the additional anti-virals **(SJ3/164 - INQ000236362)**. At that point in time, the clinical advice was that it was not clear that vaccination would be as effective against omicron so it was particularly important that we had an adequate supply. Again, it took far too long for the Treasury to agree. I wrote again on 10 December 2021 to the PM and his Chief of Staff to indicate that another week had passed without a decision on anti-viral. There was no direct response from the Prime Minister within this WhatsApp chain.

258. I am asked to identify who the key decision makers were in respect of the anti-viral purchasing decision in December 2021. The ultimate decision maker was the Treasury who made a decision what the DHSC could or could not fund, and the Prime Minister's view was also important. I would not have discussed this with the Chancellor directly – it would have been something negotiated between officials. I raised the issue with the Prime Minister at the sidelines of the 8.30am and cabinet meetings asking him to put pressure to resolve this. I was aware that the Treasury was of the view that we should fund the course of antivirals by making cuts elsewhere in the Department, but my view was that there was nothing that I could cut at this notice as we needed to purchase the anti-viral quickly. It was only on 19 December 2021 that an agreement was reached to buy the two antivirals, which included a discount on molnupiravir, which involved a further 1.75 million courses of molunpiravir and a further 2.5 million courses of Paxlovid.

259. On 8 December 2021, I made a public announcement about the "Panoramic" study **(SJ3/166 - INQ000480710).** This was a UK wide study funded by the NIHR to find out which new ant viral treatments for Covid 19 could be used in the community. This trial was open to those who had Covid, and they were either over 50 or 18 and over with pre-existing conditions (which ranged from Chronic respiratory, heart, kidney, and liver problems, to chronic neurological problems and some learning disabilities, and those in care homes or with severe mental illness). Further details about this are set out in the witness statement of Eddie Gray Witness Statement.

260. I was not party to further discussions about the trial which were held and dealt with by the ATF team as my priority at that time was to try and encourage as much vaccination as possible during the booster campaign. The results of that trial were good and show, to my lay view, that a stockpile of antivirals which can be broad spectrum in their coverage would be useful.

261. I did receive a note from Eddie Gray on 10 January 2022 concerning the manufacturing capacity of antivirals **(SJ3/167 - INQ000410547).** I am asked whether a note was ever produced in respect of a future strategy using antivirals: I understand that despite looking we have not been able to find such. My view was that they should push the point that antivirals are protection against variants in a future strategy **(SJ3/168 - INQ000480689)**. I also received a note from him on 28 March 2022 summarising his thoughts **(SJ3/169 - INQ000410561).** In that note, Eddie Gray asked about Future Pandemic Preparedness, I am asked about this. There was a team at the DHSC whose role it was, along with UKHSA and other bodies to undertake work on pandemic preparedness. It was my role as Secretary of State to sign off on the resources required and/or to ask the Treasury for the resources in order to be able to fund such preparedness. The DHSC undertook a significant amount of work about pandemic preparedness, and I was sighted and made relevant decisions as and when required. I do not consider that I can usefully assist further in answering this question without answering questions about pandemic preparedness more generally which was the subject of discussion in Module 1. Part of pandemic preparedness is having a stock of antivirals and other relevant drugs where appropriate.

262. In February 2022, the government issued a document called Living with Covid which set out some of the actions which would be continued such as continuing domestic surveillance and setting out some of the lessons learned **(SJ3/170 - INQ000086652)**.

Devolved administrations and antivirals

263. As described in the corporate witness Module 4 statement B at paragraph 122, the UK government procured these drugs on behalf of all four nations. Those drugs were then distributed according to the requirements of the population. I cannot remember any concerns being raised by the devolved administrations about this. As I have identified above, my relationship with health Ministers across the UK was good, with a weekly meeting at which views, ideas and progress could be frankly shared. My goal was to make sure that there was equitable and appropriate access for every citizen in the UK to such drugs as were available.

Use of the antiviral drugs

264. I would like to stress that the entire focus of the procurement of these drugs was to help those in high risks groups, and I consider that there has been relatively little attention paid (by the public) to the significant success and assistance that these antivirals provided, primarily because they were not the subject of large scale publicity, largely because the government needed people to use vaccination as the primary mechanism of protection against the virus, with antivirals being a valuable tool for those who could not be vaccinated or will still at a particular risk.

265. The system set up by the NHS did, I think, work well (or at least at the time I cannot remember any significant criticisms being raised). Those who would benefit from these drugs had a PCR test ready for them, and a courier would come and pick up the test so that the results could be processed quickly. A courier would then arrive the next day with antivirals. I think that this programme saved a lot of lives.

REFLECTIONS

Antivirals

266. I would certainly advise any future government dealing with a pandemic to seek to buy in relevant drugs, on an insurance basis. As has been identified by others during this Inquiry, there are many items which as a society we purchase knowing, or hoping, they will never be used; the most obvious being our nuclear deterrent. In a pandemic one needs to have quick access to the relevant tools at our disposal immediately and no production schedule (particularly given the competition between countries) will ever be sufficiently quick. I consider that the government should have a consistent stockpile or antivirals, or other drugs as advised by those who are clinically expert. I do not consider that buying the antiviral drugs as we did in December 2021 was a waste of money. On the contrary; there was no way we would or could know that these drugs would not be needed. The same logic applies with PPE: if supplies are not purchased in advance, then when they are finally required there will be serious questions asked as to why there was nothing already in place for such an eventuality. The fact that these items are ultimately not used or there is some excess is not the right way of measuring whether the decision to purchase them was the correct one.

267. The UK did not have any large pharmaceutical capability to manufacture antivirals, and both sets of antivirals purchased by us were from US firms. I consider that any future government should invest in, subsidies, and support through the provision of monies for research for new drugs but also the manufacturing of those drugs as an insurance policy. The antivirals used during Covid were made in the US. That meant that the US came first for orders. Without sovereign capacity to fast develop antivirals in an emergency, the UK will always be at the mercy of other countries.

268. I also consider that I spent too much time arguing for the procurement of these antivirals with the Treasury, something which I consider lead to us having to pay a larger sum of money than would have been the case had we had the authorization quickly. This process and Treasury approach can be contrasted with their approach to the vaccines, where they were willing to spend money on vaccines that may not be needed and to pay for what was required. I consider that the approach by the Treasury

was unhelpful, long winded, frustrating and we were lucky that it did not cause serious damage.

269. The procurement of these antivirals contributed to a wider package of measures of preparation and mitigation – our world-leading vaccine programme, comprehensive testing provision, and efforts to maximise NHS capacity. Taken together these meant the UK was incredibly well positioned, possibly more so than any other country, for coming through the Omicron wave and easing lockdown restrictions as soon as we did.

270. I have no particular lessons learned in respect of therapeutics save for what I have identified above which is the need for the Treasury to be able to act flexibly and quickly where required.

NHS

271. I have stated my reflections on the NHS at paragraph 134-139 of my Module 2 Witness statement. As stated, it became self-evident that other Western European Countries all had more capacity in healthcare during the Covid Pandemic and believe the NHS needs to adequately funded from sources other than just general taxation.

Vaccinations

272. The UK needs to develop its own MRNA vaccine making capability for the same reason I articulate above in respect of antivirals.

Need for insurance

273. The primary lessons for any government for the future is that spending (relatively) small sums of money now will save billions later and to be willing to spend money on pandemic planning, stockpiles and contingency measures. I have already stated in my witness statement for Module 2 that I wanted there to be greater levels of continued testing, oversight and surveillance than eventuated in the "Living with Covid" plan and I want there to be sufficient surveillance systems in place (for example through waste water testing) to ensure that a new pandemic can be identified early. I am aware that it is very hard in a democratic system to prioritise spending which may never then be used, and historically, it has not been electorally

attractive, but I consider that if the general public viewed it as an insurance policy then they would understand the importance.

274. Everyone accepts purchasing car, house, or travel insurance as a necessary part of life: I would like pandemic spending to be seen in the same way by all governments – as necessary expenditure, and not expenditure which can be cut, reduced, minimized or forgotten where there are financial squeezes.

275. I consider that there needs to be a way to create pandemic preparedness as a standing budget item which cannot be removed. A tentative suggestion is to pass legislation which requires an independent annual report on preparedness that sets out the spending required for adequate preparedness, provides ideas for what should be stockpiled, and which can identify which recommendations have not been implemented. I consider that the government would then find it more difficult to ignore recommendations because there is a firm basis for accountability, and because a body – set up by statute – has asked for this.

Artificial intelligence

276. I also strongly believe that artificial intelligence needs to be embraced and implemented into the NHS as quickly as possible. The NHS, MHRA and other bodies have a lot of data available, and there is more data held in other relevant departments. Artificial intelligence can be transformative in terms of helping to advise and to conduct behavioural analysis. The UK should be at the forefront of that, and this should be key to any future pandemic preparedness planning. It can play both a preventative role but also assist in how we respond to a pandemic, for example in informing our decisions on how we vaccinate. At the moment, all behavioural analysis is done by humans, but artificial intelligence could potentially be able to produce analyses that humans simply cannot. I recognise that the NHS has already started to invest in this, but I feel this is an improvement which is so obvious and so beneficial, that it needs to get on with it.

Statement of Truth

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

Signed: Personal Data

Dated: 02/10/2024