Witness Name: Rt Hon Kemi Badenoch MP

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THE UNITED KINGDOM COVID 19 INQUIRY

MODULE 4 WITNESS STATEMENT OF KEMI BADENOCH

MEMBER OF PARLIAMENT FOR SAFFRON WALDEN

SECRETARY OF STATE FOR THE DEPARTMENT FOR BUSINESS AND TRADE, SECRETARY OF STATE FOR INTERNATIONAL TRADE, PRESIDENT OF THE BOARD OF TRADE & MINISTER FOR WOMEN & EQUALITIES

I, Kemi Badenoch, WILL STATE, as follows: -

Introduction

1. I make this statement to describe my role as then-Minister for Equalities in relation to the Covid-19 vaccine roll-out between 13 February 2020 and 28 June 2022. The statement is based upon information and documents within my personal knowledge, information provided to me by colleagues within my Private Office and the Equality Hub, and my own experience of the functions and operation of government. I recognise that further documents and emails might be brought to my attention in due course, and I would welcome the opportunity to supplement, clarify or update my evidence, if necessary, in the light of any such documents. The statement can helpfully be read in conjunction with my statement in relation to Module 2, and the corporate statements of the Equality Hub in Module 2 and Cabinet Office in Module 4.

2. I was first elected as the MP for Saffron Walden on 8 June 2017. I served as Parliamentary Under-Secretary of State (Minister for Children and Families) at the Department for Education ('DfE') from 27 July 2019 to 13 February 2020. I took maternity leave from 4 September 2019 and returned to work on 7 April 2020. The Rt Hon Michelle Donelan MP covered my DfE role between 4 September 2019 and 13 February 2020. Between 13 February 2020 and 15 September 2021, I served as Exchequer Secretary to the Treasury and Minister for Equalities. Between 16

September 2021 and 6 July 2022, I served as Minister of State at the Department for Levelling Up, Housing and Communities ('DLUHC') and Minister of State for Equalities. On 6 September 2022, I was appointed Secretary of State for International Trade and President of the Board of Trade. On 25 October 2022 I was also appointed Minister for Women and Equalities. Retaining those positions, I was further appointed Secretary of State for the Department of Business and Trade on 7 February 2023.

Role and responsibilities as Minister for Equalities and later Minister for Women and Equalities

3. During the Module 4 period, the Minister for Women and Equalities was the Rt Hon Elizabeth Truss MP, a role she held between September 2019 and September 2022, alongside the roles of Secretary of State for Trade and Foreign Secretary. She had overall responsibility for the work of the Cabinet Office's Equality Hub (save for disability policies), and delegated responsibilities to junior ministers as follows.
    a. I was Minister for Equalities from February 2020 to July 2022 based in the Treasury (HMT) and then DLUHC (from September 2021). During this period, I was responsible for the Covid-19 Disparity Reports.
    b. Mike Freer MP was Minister for Equalities with responsibility for LGBT policy from September 2021 to July 2022 based in the then-Department of International Trade.
    c. Baroness Berridge of the Vale of Catmose was Minister for Women from February 2020 to September 2021 based in DfE.
    d. Justin Tomlinson MP was Minister for Disabled People from 2019 to September 2021, followed by the Rt Hon Chloe Smith MP from September 2021 to September 2022, both of whom reported to the then-Secretary of State for Work and Pensions, the Rt Hon Thérèse Coffey MP.

4. Together, we had regular ministerial team meetings with bilateral meetings where necessary.

5. My specific responsibilities as Minister for Equalities between 16 February 2020 and 28 June 2022 included **[KB/1 - INQ000185181]**:

    a. work relating to racial and ethnic disparities, including the Commission on Race and Ethnic Disparities and, subsequent to the Commission's report,

publication and delivery of the Government's response, Inclusive Britain, which I announced on 17 March 2022,

b. supporting the Minister for Women & Equalities on work relating to LGBT equality, including responding to the consultation on reforming the Gender Recognition Act, banning conversion practices and hosting a global LGBT Conference (work which was mostly reallocated to Mike Freer MP on his appointment),
c. work relating to COVID-19 disparities, including the four quarterly reports on this to the Prime Minister between June 2020 and December 2021,
d. acting as sponsoring minister for the Social Mobility Commission (from April 2021) and the Equality and Human Rights Commission, and
e. oversight of the Equality Act 2010 and Public Sector Equality Duty.

6. Throughout the pandemic I worked closely and effectively with Marcus Bell and his staff at the Equality Hub. To avoid unnecessary duplication, I defer to Mr Bell's statement in Module 2 for his overview of the structure and work of the Equality Hub **[KB/2 - INQ000198850]**.

Work relevant to the vaccine roll-out

7. So far as is relevant to Module 4, the key work for which I was responsible included:
    a. Providing the Prime Minister and Health Secretary with the four quarterly reports on progress to address Covid-19 health inequalities in October 2020 and February, May and December 2021. [On 4 June 2020, the Prime Minister had invited me to lead on work by the Government following the Public Health England review into disparities in the risk and outcomes of COVID-19 **[KB/3 - INQ000101218]**. I was provided with eight 'terms of reference' **[KB/4 - INQ000089741]** and between June 2020 and December 2021, most of my time was spent working with the Equality Hub to deliver against these].
    b. Attending some Covid-O meetings in relation to disproportionately impacted groups and in particular ethnic minorities.
    c. Improving public health communications about the impact of COVID-19 on ethnic minority groups.
    d. Working with the Equality Hub and national and local partners to increase vaccine uptake among ethnic minorities and to tackle misinformation.

8. While I was often briefed on issues in relation to disabled people, as part of the wider 'disproportionately impacted groups' strand of work, my colleague, Justin Tomlinson MP, the then-Minister for Disabled People (MfDP), was responsible for considering issues relating to vaccine deployment for disabled people. He was supported in this work by officials in the Equality Hub's Disability Unit (DU).

9. The DU worked across government departments to identify risks affecting disabled people and supported departments to mitigate these. Some examples of this include:

    a. Supporting the vaccination programme in relation to the needs of disabled people, including helping to ensure that vaccination centres were easily accessible in terms of location, hours, and physical access,
    b. Connecting decision-makers with their stakeholder networks by, for example, inviting the then-Minister for Covid Vaccine Deployment to attend a meeting of the Disability Charities Consortium on 25 January 2021 to hear first-hand from disability charities, and
    c. Holding a roundtable with disability stakeholders on 23 March 2021 as part of the Covid Vaccine Certification Review. Through this discussion the Covid-19 Taskforce identified a number of potential issues with the policy including: (i) equalities concerns for people for whom vaccination or regular testing would cause distress and (ii) ensuring the process was fully accessible for people with disabilities. DU fed into the development of the equality impact assessment for the Covid status certification (April 2021) with the Covid Taskforce.

Input into decision-making

10. The Equality Hub and ministerial team had the following opportunities to feed into key decisions.

11. I shared the findings of the first three quarterly reports with the Chair of the Joint Committee on Vaccination and Immunisation, Professor Wei Shen Lim, in December 2020, March 2021, and May 2021, to help inform the vaccination programme **[KB/5 - INQ000083875, KB/6 - INQ000083884 and KB/7 - INQ000185168]**. The DHSC had initially suggested it would be inappropriate for me to write to the JCVI as this could be deemed as lobbying an independent body. My letters were factual in tone and reflected the evidence we had gathered over the course of my work.

12. I attended the following Covid-O meetings at which vaccination was discussed:

a. 10 December 2020 on risk stratification. This meeting included approving the Covid-19 risk assessment model to support vaccine prioritisation (risk stratification). **[KB/8 - INQ000486427 and KB/9 - INQ000185174].**

b. 25 January 2021 on vaccine uptake **[KB/10 - INQ000091823]**. This meeting was also attended by the Minister for Disabled People. It was agreed that national communications and messaging should be supportive and reassuring and avoid stigmatising communities. I took away actions to:

   i. Explore which community representatives and influencers have been effective in tackling disinformation to date and ensure partners to be used in this campaign are trusted voices.

   ii. Establish indicators for measuring the effectiveness of the communications campaign, drawing on insights from my previous work on reporting disparities **[KB/11 - INQ000092300]**. There were challenges in isolating the impact of this specific campaign, given the volume of communications on promoting vaccine uptake from multiple sources (including central and local government, NHS bodies, charities, faith organisations and individuals on social media). It was therefore difficult to establish specific indicators for measuring the effectiveness of the campaign, although I received weekly updates via analysts in the Equality Hub about the rates of vaccine uptake by ethnic group, which was a broad proxy for measuring the effectiveness of the communications campaign. In addition, my final quarterly report (pages 55 and 60) set out the more detailed indicators that were put in place by the central Cabinet Office communications team to monitor impact of the vaccination communications campaign. The communications team worked with specialist agencies to establish robust and representative sample sizes comprising ethnic minority audiences across campaign research, including audience insight to establish baseline figures on ethnic minority audiences' attitudes and behaviours on Covid-19, including vaccine uptake. This research was then repeated to measure any changes to attitudes and reported behaviour change against the pre-campaign baseline.

c. 17 March 2021 on vaccination as a condition of deployment in health and adult social care settings **[KB/12 - INQ000092064]**. I did not support mandating

vaccines in the NHS at that stage, given the workforce risks **[KB/13 - INQ000185173]**. These risks included the potential impact on workforce numbers should social care workers choose to leave their roles in large numbers, rather than be vaccinated. This risk was particularly pronounced for ethnic minority women who were overrepresented within the adult social care workforce and who, at the time, were less likely to be vaccinated (particularly because of unfounded fears about the impact of vaccination on pregnancy and fertility). My brief also included reservations about extending the policy to those working in care homes who had no direct contact with residents. The briefing drew on information learned in a meeting I had held two days earlier with the BAME Communities Advisory Group, which was established as part of the Social Care Sector Covid-19 Support Taskforce. Covid-O agreed with the DHSC's proposal that secondary legislation should be introduced to protect the most vulnerable from COVID-19 by making vaccination a condition of deployment for those working in older age residential care homes, including a carefully considered handling plan. I raised the workforce risks in the meeting and shared the views of the BAME Communities Advisory Group. That Group had raised concerns that making vaccines a condition of deployment would risk damaging trust with the workforce. I agreed with this, although my own view was that the levels of trust within the workforce were already so low that the impact of introducing vaccines as a condition of deployment should not be overplayed. The Committee held that the DHSC should develop a robust handling plan to address vaccine hesitancy and equality issues relating to vaccine uptake and provide a plan to assess and mitigate the likely impact of these measures on the adult social care workforce **[KB/14 - INQ000092400]**. I envisaged that this handling plan would focus on stressing the public health advantages of vaccination (both for social care workers and care home residents) and addressing the drivers of vaccine hesitancy such as tackling misinformation (including the concerns about the impact of vaccines in pregnancy and on fertility). I was also aware that some ethnic minority groups tend to have lower levels of trust in UK institutions and that the handling plan had to help build trust and not to stigmatise those who had concerns about vaccination. I did not underestimate the scale of the challenge with delivering this handling plan in what was to have been a relatively short period of time. I still had very real concerns that the plan would be insufficient to overcome the levels of vaccine hesitancy and that a number of healthcare workers would no longer have been able to work in this sector.

d. 20 May 2021 on Covid-19 status certification **[KB/15 - INQ000083916, KB/16 - INQ000083889 and KB/17 - INQ000083897]**. Vaccine certification was one of the proposals being considered for implementation as part of "Step 4" of the roadmap out of Covid recovery **[KB/18 - INQ000089798]**. This meeting was to agree proposals for domestic vaccine certification which would inform preparation for the delivery of this policy, so it was ready to be implemented if needed. I was briefed on the equality concerns with the proposals ahead of the meeting, in particular the impact on disabled people who cannot self-administer at-home tests, those for whom repeated testing and vaccinations would be distressing, and those who are digitally excluded. My brief also highlighted the risk of undermining promotion of the vaccine if certification were seen as mandating vaccination or stigmatising those with lower vaccination rates.

e. 15 June 2021 on vaccination as a condition of deployment in adult social care settings **[KB/19 - INQ000092238 and KB/20 - INQ000185169]**. Following the meeting on 17 March 2021 (above), DHSC had carried out a consultation on the proposals (from 14 April to 26 May). This meeting was to agree to publish the Government response and next steps. The response recognised the equality concerns with the approach and set out proposed mitigations to manage these. The committee agreed to the publication, and to further consultation on wider proposals. This led to the Equality Hub engaging with DHSC on their draft consultation **[KB/21 - INQ000083910]**. The Equality Hub also contributed to the consultation 'Making vaccination a condition of deployment in the health and wider social care sector' **[KB/22 - INQ000089758]** and the accompanying equalities impact assessment **[KB/23 - INQ000092156]** published in September 2021.

13. I met the chairs of the SAGE Ethnicity Subgroup (Professor Kamlesh Khunti and Osama Rahman) on 21 October 2020 **[KB/24 - INQ000185147]** and 16 December 2020 to discuss likely disparities in Covid vaccination rates.

14. I met the Home Secretary and Chancellor of the Duchy of Lancaster on 30 March 2021 to discuss vaccine certification **[KB/25 - INQ000083898]**.

15. I met the Minister for Covid Vaccine Deployment, the Rt Hon Nadhim Zahawi, on 20 January and 11 May 2021, to discuss how to increase vaccine uptake among ethnic minorities **[KB/26 – INQ000083911, KB/27 – INQ000486428 and KB/28 – INQ000486429].**

16. On 21 July 2021, I met the then-Deputy Chief Medical Officer, Tom Waite, to discuss Covid-19 disparities and vaccine uptake **[KB/29 – INQ000185170]**. During the meeting I flagged the difficulties the Equality Hub had experienced with sharing health data across government departments and agencies. These concerns were recorded in my fourth quarterly report, which noted that our evidence base would have been improved by the publication of data about: the number of COVID-19 deaths of healthcare workers by ethnicity; the number of hospital-acquired COVID-19 infections and deaths; and the uptake and use of the NHS COVID-19 app by different ethnic groups. As Marcus Bell's statement also noted (page 48), it would have been helpful to have access to NHS Electronic Staff Record data by ethnicity so the UK-REACH team could link with regulator data and healthcare outcomes. I shared this view.

17. Officials in the Equality Hub also worked closely with DHSC colleagues, particularly around ethnicity data from the vaccination deployment to enable us to monitor any ethnic disparities in vaccination rates.

18. Finally, officials in the Equality Hub regularly attended meetings of the NHS England's Vaccine Equalities Deployment Committee. This Committee was established in January 2021 and comprised representatives from government departments, the Association of Directors of Public Health, local authorities, fire and police services and third sector organisations. The Committee, which had an independent chair (Clive Lewis OBE), focused on driving uptake of the vaccine among DIGs. Initially the group met weekly, but the frequency decreased from March 2021.

19. In addition to those factors which I brought to the attention of the JCVI and Covid-O, it was clear to me that JCVI were considering equality issues in the vaccine roll-out.

20. The JCVI advised in December 2020 **[KB/30 - INQ000408135]** that the first priorities for the Covid vaccination programme should be the prevention of Covid mortality and the protection of health and social care staff and systems. The evidence showed that age and clinical vulnerability (which applied to many disabled people) were the drivers of worst outcomes from Covid-19.

21. The JCVI recommended prioritising frontline healthcare workers for vaccination, a significant proportion of whom are from an ethnic minority background. This group was also a focus of our communications efforts in terms of promoting vaccine uptake.

22. The JCVI also considered the risks to pregnant women and, initially, advised that there was insufficient evidence to recommend routine use of COVID-19 vaccines during pregnancy. Once more was known about the safety of the vaccine, the government and NHS England took considerable efforts to encourage pregnant women to come forward to be vaccinated.

23. The JCVI statement on Phase 2 of the vaccination programme **[KB/31 - INQ000420904]**, published on 26 February, advised that deployment teams should actively promote vaccination uptake with individuals who were: male, those who were from an ethnic minority background, had a BMI of 30 or more, and those from areas of high socio-economic deprivation.

24. Geographical differences were addressed through measures such as the Community Champions scheme. Public health and demographic data were used to identify which local authorities received the funding. Factors such as the percentage of local population with little or no English, areas with high levels of residential segregation and areas with a high density of disabled people were used to identify the local authorities that would most benefit from additional activities to engage their local communities in government health messaging.

25. A significant focus of our communications efforts was on those for whom English was not their first language. Measures included:

    a. deploying multilingual vaccine ambassadors across 61 local authorities to encourage vaccine uptake through outreach and direct communication (operating in over 20 languages, the team addressed questions and concerns on COVID-19 vaccines),
    b. partnerships with community radio and TV stations, broadcasting messages in several languages, and
    c. translating core marketing materials, communications assets and guidance materials into several languages, such as Bengali, Chinese, Gujarati, Hindi,

Punjabi, Urdu and Somali, with additional translations supported where local authorities required.

26. On 19 May 2021, I held a roundtable with High Commissioners from countries whose nationals were most at risk from Covid-19 to encourage the uptake of vaccines amongst their diaspora networks. **[KB/32 - INQ000486430]**. Following this roundtable, I sent letters of thanks which suggested that the Equality Hub could work in partnership with each High Commission by disseminating the latest public health messaging around COVID-19 thereby continuing to maximise vaccine uptake across the country **[KB/33 – INQ000486431 and KB/34 – INQ000486432].** To my recollection, none of the High Commissions took us up on this offer.

27. I was aware that immigration status was considered as part of the government's communications strategy and the vaccine deployment programme. As my fourth quarterly report noted, Public Health England produced two animations explaining immigrants' entitlement to vaccination **[KB/35 – INQ000420914]**. There were also pop-up clinics, including at a hotel in north London, which vaccinated those without permanent residency or an NHS number **[KB/36 – INQ000420908]**.

28. In my view, the vaccine roll-out procedures were adequately tailored to meet the needs of those groups with lower levels of vaccine uptake. The measures adopted by the government played a significant role in mitigating the impact of the pandemic in terms of increasing both positive vaccine sentiment and vaccine uptake across all ethnic groups. The data shows that overall vaccine confidence increased from 49% (10 December 2020 to 10 January 2021) **[KB/37 - INQ000420910]** to 70% (31 March to 25 April 2021) **[KB/38 - INQ000420909].**

29. Vaccine uptake also increased among all ethnic groups in 2021. The largest percentage point increases were in the Pakistani ethnic group (from 73.1% to 83.7%, up by 10.6 percentage points) and black African ethnic group (from 64.9% to 75.1%, up by 10.2 percentage points) **[KB/39 - INQ000421788]**.

30. We did experience some obstacles in relation to data sharing with NHS England, leading to the inclusion of a priority recommendation in my final quarterly report that an independent strategic review be undertaken of the dissemination of healthcare data and publication of statistics and analysis.

Structures and processes by which equalities issues fed into decision-making

31. In my view, the structures, and processes in place enabled core decision-makers to mitigate the impacts of the pandemic on relevant groups, and on ethnic minorities in particular. I found that the Covid-O Committee provided an extremely valuable forum through which to secure collective agreement. Although I recall that there were frustrations raised at the time around papers being circulated at the last minute (often due to the speed with which meetings were organised and agendas produced) all structures have limitations, and I cannot think of a better structure in the circumstances.

Public Sector Equality Duty (PSED) and Equality Impact Assessments

32. Individual government departments are responsible for understanding the equality impacts of their own policies through compliance with the PSED. There is no separate duty on the Equality Hub or Minister for Equalities to review or monitor other government departments' equality impact assessments or their approach to PSED.

33. Occasionally we are asked to give guidance to departments about their equality duties. For example, officials within the Equality Hub contributed to PSED analysis of the decision to make vaccination a condition of deployment in health and social care settings, raising concerns about impacts on the workforce, a large proportion of whom were from an ethnic minority background.

34. I wrote to all government ministers on 8 December 2021 on the subject of the PSED. I reminded them that their departments are responsible for proper consideration of the equality impacts of their policies and of their ongoing duty to consider equality in their work and their departments. I also provided them with advice on how their departments might approach equality impact assessments and the appropriate documentation of their decision making **[KB/40 - INQ000089735]**.

Monitoring unequal impacts and decision outcomes

35. I was keen to monitor the impact of decisions on ethnic minorities. Through officials in the Equality Hub, I pushed for collection of patient ethnicity data in relation to vaccination **[KB/41 - INQ000420898]**. Ethnicity data was not routinely collected from patients at the start of the vaccination campaign. Instead it was linked from people's

health records, such as Hospital Episode Statistics. The Equality Hub raised this with the NHS England Director of Data in January 2021, shortly after which data was collected directly from the patient at the time of vaccination. The data was then published on a weekly basis, and I was regularly briefed by Equality Hub officials on this, including any disparities. I was also regularly briefed on Covid infection and mortality rates broken down by ethnicity.

36. This was used to target our engagement and communications. For example, the data showed that specific ethnic minority groups had lower uptake, including the Bangladeshi and Pakistani groups who were also at greater risk of Covid infection in the second wave of the pandemic. In response to this, I held roundtables considering how to increase vaccine uptake with a focus upon Pakistani and South Asian Groups on 5 February 2021 and with community leaders/groups on 5 March 2021 **[KB/42 - INQ000185160]**.

37. As noted above, the DU worked to raise any questions or concerns disabled people had about vaccines in the heart of government. The Minister for Disabled People engaged with disability stakeholders to ensure the accessibility of the vaccination programme and guidance.

38. As noted above, the Minister for Covid Vaccine Deployment was also invited to speak directly with disability stakeholders to ensure that disabled people's voices were being heard.

Disparities in vaccine coverage in ethnic minority groups

39. In my first quarterly report, published on 22 October 2020, I highlighted that ethnic minorities were more likely to be targeted by misinformation and less likely to be vaccinated. Recommendation 13 of that report said: "Further work is needed to dispel myths, reduce fear, and build confidence among ethnic minority people. Over the coming months, the COVID Communications Hub in the Cabinet Office will need to keep sharpening its focus on rebuilding trust in government messaging, tackling misinformation and anti-vaccination narratives and encouraging engagement with NHS services".

40. These concerns were reflected in the early stages of the vaccination programme, with lower levels of uptake among specific ethnic minority groups. I highlighted this in my

second quarterly report, published in February 2021, which noted: "Lower COVID-19 vaccine uptake is evident for some ethnic minority groups in vaccines administered to over 80s as of 4 February. The vaccine rates for eligible Black African, White, and Black African, Other Black, Bangladeshi and Pakistani people are notably low (45.1%, 51.5%, 53.4%, 54.6% and 55.2% respectively). This compares to 82.8% of eligible White British people having received a vaccine."

41. That report included a commitment for the government to "continue to monitor data on vaccine uptake among ethnic minority groups and, if necessary, take further steps to address any barriers among these groups".

Factors leading to disparities in vaccine coverage

42. Previous national vaccination programmes in the UK have reported lower vaccine uptake in areas with a higher proportion of ethnic minority group populations **[KB/43 - INQ000250215]**. Some of the barriers to vaccine uptake include "perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders".

43. This was reinforced by the 'Perceptions of the Pandemic research', commissioned by the Equality Hub, which took place during July and August 2021 and is summarised in my final quarterly report.

44. This project gathered ethnic minority members of the public's views on the pandemic response across a wide range of government interventions, helping to identify areas of good practice in terms of support services, communications, and engagement activity.

45. This study also found that of all respondents, 26% did not trust the vaccine and 16% disagreed that we all have a duty to vaccinate. For the respondents who were still hesitant about the vaccine (9% of the total sample), reassurance was needed about side effects and the speed with which it was developed. The groups with the highest percentage of respondents likely to be hesitant about the vaccine were the Bangladeshi (19%), and black African (18%) ethnic groups, people aged under 35 (15%) and parents of young children (15%). Of all respondents who were hesitant or not planning on having the vaccination (17% of the total sample), the main concerns

were around the side effects (31%), the speed with which it was developed (32%), not trusting the vaccine (33%) and believing vaccination should be a personal choice (35%).

46. It was also found that those not planning on having the vaccination were less likely to be concerned about the pandemic and more likely to rate the government's response poorly, suggesting that they may be more difficult to reach or influence. The two groups most likely to say they did not plan on having the vaccination were the mixed white and black African group (19%) and people who were not concerned about the pandemic at its start (18%).

47. Trust was clearly a major issue. There were multiple drivers of the levels of mistrust in the vaccine. I was aware of some concerns that clinical trials would be performed on ethnic minorities without their consent (often accompanied by references to historical examples such as the Tuskegee study in Alabama in the 1930s) which were being cited as reasons why the Covid vaccines could not be trusted.

48. The Perceptions of the Pandemic research confirmed that there were concerns around the side effects of the vaccine and the speed with which it was developed, which were no doubt exacerbated by the lower proportion of ethnic minorities participating in clinical trials of the vaccine.

49. As I said when I appeared before the Inquiry in Module 2, I also saw first-hand how social media could be used to undermine trust. I saw family WhatsApp messages, often sent from abroad, with conspiracy theories about the vaccines. Many of these messages amplified existing concerns about the safety of vaccines. This misinformation further undermined trust in UK health services and in the vaccination programme.

50. An Ofcom study **[KB/44 - INQ000420912]** showed that people from ethnic minority backgrounds were twice as likely as white respondents to rely more on people they knew, people in their local area or people on social media for information about Covid and vaccines than traditional media. They were therefore particularly susceptible to misinformation.

51. There were also religious concerns, particularly within the Muslim community, about whether the vaccines contained animal products.

Steps taken to address disparities

52. We took several steps to address these disparities beginning with a recommendation in my first quarterly report in October 2020 about the need to rebuild trust in government messaging and tackle misinformation and anti-vaccination narratives.

53. I knew that one way to address hesitancy was to show that vaccines were safe. I volunteered to take part in the Novavax vaccine trial in October 2020 **[KB/45 - INQ000420900]** and wrote to all MPs that month urging them to encourage more of their ethnic minority constituents to sign up to the NHS Vaccine Registry and participate in trials.

54. I held a series of roundtables with ethnic minority healthcare professionals and religious and community leaders, encouraging them to act as ambassadors within their communities. I - and officials in the Equality Hub - also regularly engaged with our counterparts in the DHSC. This included:

    a. a meeting with the British Medical Association on 14 December 2020 at which we discussed vaccine hesitancy and the important role of ethnic minority healthcare workers in promoting vaccination **[KB/46 - INQ000185153]**,
    b. a meeting on 7 January 2021 with the National Pharmacists Association (NPA) to consider how to increase vaccine uptake **[KB/47 - INQ000477623]**. The NPA highlighted that the distribution of community pharmacies is heavily skewed towards areas of greater deprivation, in contrast with other health services, and that such pharmacies enjoy high levels of trust among the people they serve. The NPA also pointed out that most people live within walking distance of a community pharmacy. These factors meant that community pharmacies were uniquely placed to encourage vaccine uptake, particularly among ethnic minority groups. A number of actions were agreed at the meeting including for the NPA to facilitate pharmacist involvement in the government's communications campaign (part of our wider work to encourage ethnic minority healthcare workers to promote vaccine uptake), and for the NPA to notify the government of examples of vaccine misinformation gathered by community pharmacies. These were largely matters for the DHSC and for my ministerial colleagues Jo Churchill MP, as Minister for Public Health, and

Nadhim Zahawi MP, as Minister for Vaccine Deployment, who also attended the roundtable.

c. roundtables on how to increase vaccine uptake with a focus upon Pakistani and South Asian Groups on 5 February 2021 and with community leaders / groups on 5 March 2021 **[KB/42 - INQ000185160]**, and
d. a meeting with Lord Greenhalgh, the then-Minister for Communities, on 20 May 2021 to discuss DLUHC's work in promoting vaccine uptake among faith groups **[KB/48 - INQ000185167]**, and
e. a roundtable with High Commissioners on 19 May 2021 to encourage the uptake of vaccines amongst diaspora groups.

55. One of the key steps to improve vaccine confidence was the Community Champions scheme (see section below), announced in my first quarterly report, which was launched in January 2021. It allocated £23.75 million in funding to 60 councils and was designed to expand work to support those most at risk from COVID-19 and to boost vaccine take up.

56. Other initiatives included:

a. setting up vaccination centres in around 50 places of worship and using many more as pop-up venues,
b. bespoke programmes to increase vaccine confidence in black African, black Caribbean, Bangladeshi and other groups, working with religious leaders, other trusted community voices and ethnic minority healthcare workers,
c. initiatives targeting religious events such as Easter and Ramadan to address vaccine concerns and promote uptake,
d. supporting and advocating the use of mobile and community vaccine pop-ups to increase access to underserved communities, culminating in the launch of the national 'Grab-A-Jab' programme from July 2021,
e. several measures to improve uptake among ethnic minority healthcare professionals including webinars and question and answer sessions with ethnic minority medics,
f. working with the BBC Asian Network and BBC World Service to produce Covid 19 videos to address important questions from South Asian groups, delivered through trusted voices and outlets,
g. working with faith leaders to promote vaccine uptake, tying in with key religious festivals and using places of worship as vaccination centres,

h. producing a video promoting vaccine uptake among healthcare workers, which featured a broad range of ethnic minorities,
i. producing videos with faith and business leaders from the Bangladeshi community and delivering a webinar in partnership with Bangladesh Caterers Association to increase vaccine uptake amongst the Bangladeshi group and
j. forging partnerships with predominantly African and Caribbean churches and others to develop a series of online community dialogues to provide information about the vaccine and create a safe place for questions and challenge.

57. In the early stages of vaccine deployment there were also concerns about whether being vaccinated was consistent with religious beliefs. For example, there were claims that Covid vaccines contained gelatine and were not therefore halal. The Equality Hub took several steps to help to address this including sharing a series of videos **[KB/49 - INQ000420917]** with Dr Amir Khan, a GP from Yorkshire and a media medic, on the vaccine being halal, which reached more than 330,000 people.

58. Some of these initiatives I led personally, such as the roundtables to understand and address vaccine hesitancy. Others were led by the government's expert advisers on Covid and ethnicity, Dr Raghib Ali, and Professor Keith Neal, whom I appointed. Their work included specific media briefings for journalists around the release of quarterly reports. Dr Ali also attended a series of virtual meetings with ethnic minority healthcare workers to reassure them that vaccination was safe and helped us to produce videos challenging myths about the vaccine **[KB/50 – INQ000420918]**. This included addressing concerns about the perceived risk of infertility from Covid vaccination, which was a very real barrier to vaccine uptake among female healthcare workers.

59. This was alongside wider government initiatives, such as regularly producing myth-busting content, utilising trusted platforms and messengers within communities, and taking specific targeting approaches on social media channels **[KB/51 - INQ000361190]**. This includes developing the 'Check Before You Share' toolkit **[KB/52 - INQ000420902]**.

60. The Perceptions of the Pandemic research found that the vaccination roll-out plan and the communications around the roll-out were rated highest of all government measures (rated very or quite good by 63% compared with around 10% quite poor or terrible) – at least 70% of people from the Indian, Mixed White, and Asian and Asian

Other groups rated the communications around the roll-out as very or quite good. Likewise, in respect of communications in relation to a range of issues during the pandemic, the communication of the vaccination strategy and roll-out was the highest rated, with 60% of all respondents rating it very or quite good. This was followed by the communication of the national and local measures to reduce the spread of COVID-19 (49%).

61. The research also highlighted some key lessons to be learned from this work, including:

    a. ethnicity is not the driving factor in how most ethnic minorities understood their experience of the pandemic,
    b. treating ethnic minorities as a single group is counter-productive and can be stigmatising,
    c. trust in sources of information is essential for participants' acceptance of public health messaging,
    d. ethnic minorities felt stigmatised when they were singled out in communications to imply that they are somehow more vulnerable or are at fault for the spread of the virus, and
    e. non-traditional media and communications are an important way of sharing government messaging and reaching people who might otherwise be less engaged.

62. These are reflected in some of the recommendations in my final report (see lessons learned section below).

63. Throughout 2021, I was briefed by officials in the Equality Hub on a regular basis on the latest data on the levels of vaccine uptake by ethnicity, which was a good proxy for public confidence.

Impact of existing inequalities on vaccine access and uptake

64. For ethnic minorities, lower vaccination rates were less about health inequalities in general and more specifically about a lack of trust in health institutions and confidence in the Covid vaccine. Addressing these concerns was a significant focus of our communications efforts.

Steps taken to mitigate intersectional inequalities on vaccine access and uptake

65. There are examples of where we took a multi-pronged approach to promoting vaccine uptake. For example, in my second letter to the JCVI in March 2021, I raised the possibility of 'family jabs'. There was concern about the spread of the virus among Bangladeshi and Pakistani ethnic groups during the second wave, which may have been driven by the higher proportion of those families living in multigenerational houses. These groups also had higher levels of vaccine hesitancy, particularly among the elderly. I pushed for family members living in the same household as their elderly relatives to be vaccinated at the same time, to help overcome some of the resistance we had seen among those groups.

66. For example, on 25 March 2021, I wrote to Professor Wei Shen Lim, Chair of the JCVI **[KB/53 - INQ000083884]**. In that letter, I said*: "I am keen to explore further options for increasing uptake, such as allowing adult family members living in the same household to be vaccinated at the same time, which could help to overcome some of the resistance we have seen among those groups at greatest risk of hospitalisation from C19. This is something I am discussing with colleagues and NHSEI, to see whether it is feasible for local Directors of Public Health to be given 'clinical discretion' to adopt such a policy."*

67. The concept of family vaccines was reflected in guidance issued by the NHS on 9 April 2021 which encouraged vaccine delivery partners to consider how to adapt vaccine delivery for maximum uptake, how to support the many Muslim members of staff working for the NHS, and how best to reach the Muslim population and disseminate vaccine messaging during Ramadan **[KB/54 - INQ000185163].**

68. I also realised that pregnant women, and particularly those from ethnic minority groups, were concerned about vaccination. This became a big focus of our communications efforts and the subject of a recommendation in my final quarterly report ("To reassure pregnant women that the COVID-19 vaccine is safe, the government should continue to deliver clear messaging through trusted voices and via social media"). Measures taken to address these concerns include producing a video with the then Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent and midwives around the country to address pregnancy and infertility concerns **[KB/55 - INQ000420915]**.

Public messaging on the vaccine roll-out

69. One of the terms of reference for my review of Covid disparities was to "strengthen and improve public health communications to ensure they can reach all communities across the country".

70. I took this role very seriously and was directly involved in some of the public messaging about the vaccine roll-out. For example, I used social media to encourage greater ethnic minority participation in Covid vaccine trials **[KB/56 – INQ000420916]** and to promote vaccine uptake **[KB/57 - INQ000420919]**. I wrote an article for The Voice newspaper **[KB/58 - INQ000420903]**, published on 22 February 2022, to tackle vaccine hesitancy. Dr Raghib Ali, one of the government's advisers on Covid and ethnicity, also assisted through online meetings **[KB/59 - INQ000420920]** and video content aimed at encouraging ethnic minorities to be vaccinated **[KB/60 – INQ000420921]**.

71. I also helped to shape the government's public health messaging through officials in the Equality Hub who worked directly with the Cabinet Office Covid Communications Hub (on part-time secondment including to influence and help make the best of both Equality Hub and central Covid Communications Hub work) and by providing insight on reaching specific audiences, ensuring materials were accessible or engaging our existing stakeholders.

72. The Equality Hub communications team also shared advice on language and working with specific media outlets alongside this and disseminated central messaging to stakeholder groups and channels. This included utilising the Equality Hub's social media channels with 300,000 combined followers, as well as a network of existing stakeholders covering ethnic minority groups and disability-focussed organisations.

Public messaging strategy

73. The government's public messaging strategy was planned and delivered by officials and Ministers outside of the Equality Hub. However, officials in the Equality Hub provided support where possible.

74. To drive vaccine confidence among those communities with the lowest take-up, the Government COVID communications strategy took a 'by the community for the community' approach, and delivered activities across 3 tactical pillars:

    a. community engagement and outreach (including sessions with trusted voices),
    b. media relations and community/media partnerships and
    c. marketing activities, including through tailored content creation.

75. The government's approach was to use insight-based, tailored content in clear language that resonated with different ethnic minority audiences. That meant not treating ethnic minorities as a single group and tailoring our messaging accordingly.

76. Due to the public health emergency, information was disseminated in multiple languages and through trusted stakeholders and media channels - including via the Equality Hub's own social media outlets.

77. The Hub's communication team provided resources to the central Covid communications team (via part-time secondments to ensure maximum sharing of insight and expertise) and offered advice on areas such as media engagement and social media engagement.

Steps taken to ensure public messaging was inclusive

78. The majority of public messaging was generated and delivered by government departments outside of the Equality Hub.

79. Core public outputs, communications assets and guidance materials were translated into multiple languages, such as Bengali, Chinese, Gujarati, Hindi, Punjabi, Urdu and Somali, with additional translations supported where local authorities required them to reach their residents.

80. All media output related to my quarterly reports was sent to media outlets that targeted specific communities, as well as those providing national and regional coverage. My officials held a media list of these publications and shared this with departments across government when they believed it would help a separate communications campaign.

81. Officials in the Equality Hub's Disability Unit worked closely with Cabinet Office and DHSC colleagues to promote vaccine uptake among disabled people. This included working with Public Health England on British Sign Language, braille, and large print versions of vaccine guidance and a short film from NHS England developed for people with learning disabilities. It describes what a vaccine is, how vaccines are made, why you should get a vaccine, whether a vaccine makes you ill and how to decide whether to have a vaccine or not. The Disability Unit also helped to design 'Easy Read' communications regarding vaccinations for people with learning disabilities (which feedback suggests was also a helpful resource for those without proficiency in English) and published blogs on the GOV.UK Disability Unit page providing COVID updates including vaccine roll-out **[KB/31 - INQ000420904]**.

Community Champions

82. The Community Champions scheme was announced in my first report to the Prime Minister and launched by MHCLG in January 2021 **[KB/61 - INQ000137114]**. It allocated £23.75 million in funding to 60 councils and was designed to expand work to support those most at risk from COVID-19 and to boost vaccine take up.

83. The scheme supported a range of interventions to build upon, increase or improve existing activities to work with residents who were most at risk of Covid-19 - helping to build trust and empower at-risk groups to protect themselves and their families. This included activities such as setting up vaccination hubs, circulation of translated materials in multiple languages, and online, face-to-face, and 'foot-patrol' visits to neighbourhoods to promote initiatives such as vaccination buses.

84. Alongside the direct awards to local authorities, further support to communities was delivered by two voluntary and community sector partners – Strengthening Faith Institutions and Near Neighbours - who supported community communications campaigns and other activity.

85. The Community Champions scheme was evaluated by academics from the London School of Economics, who were also members of the Independent Scientific Pandemic Insights Group on Behaviours (SPI-B). They described the scheme as "a success story of central government pandemic policy because it articulated well with local level efforts, thereby strengthening and sustaining regional capacities to deal with Covid-19" **[KB/62 - INQ000283328]**.

86. The evaluation report found that a rapid policy response directed through existing skilled local networks with knowledge of barriers and needs was "highly effective". Local authority and community champion partners reported that the scheme contributed to vaccine uptake and to growing collaboration and coordination of "social provisioning".

87. A second round of funding (a further £22.5m) was allocated to 60 local authorities via a second scheme - Community Vaccines Champions - in January 2022. This was in response to a rise in infections due to the emergence of the Omicron variant. The funding was for the delivery of bespoke projects to promote vaccine uptake and address wider health inequalities in the areas with the lowest vaccination rates in the country.

88. The independent evaluation of Community Vaccines Champions **[KB/63 – INQ000283329]** concluded that activities funded by the scheme succeeded in delivering additional Covid booster doses that likely would not have otherwise been administered.

Evaluation and monitoring of the vaccine deployment campaign

89. The evaluation and monitoring of the vaccine deployment campaign was handled by other government departments. However, our Perceptions of the Pandemic research sought views on the effectiveness of government communications on Covid. The vaccination roll-out plan and the communications around the roll-out were rated highest of all government measures (rated very or quite good by 63% of respondents, compared with around 10% quite poor or terrible).

90. We also monitored the effectiveness of the communications and engagement strategy through the data on vaccine uptake by ethnicity.

Vaccine disinformation and misinformation

91. As I said when I gave evidence to the Inquiry during Module 2, I saw first-hand how misinformation spread through means such as WhatsApp groups. I observed that I have also seen the impact of conspiracy theories about Covid vaccines and have been challenged in the street about my role in promoting vaccine uptake.

92. Misinformation and disinformation were rapidly circulated via social media, which is why it was important that the government was quick to react by tackling falsehoods via our own channels and via the Community Champions.

Steps taken to counter vaccine disinformation / misinformation

93. My final report summarised government efforts to tackle misinformation and disinformation among ethnic minority audiences. The government regularly produced myth-busting content, utilising trusted platforms and messengers within communities, and taking specific targeting approaches on social media channels. For example, government communications developed answers to specific 'myths' about the vaccine to engage women from the Ultra-Orthodox Jewish community, clarifying concerns and questions around the vaccine being kosher, and perceived links to fertility, pregnancy, and breastfeeding.

94. As noted above, the Department for Digital, Culture, Media and Sport also developed a campaign to help tackle the spread of false information about the COVID-19 vaccine. The campaign was developed with and fronted by trusted local community figures such as imams, pastors, and clinicians, who featured in short, shareable videos which include simple tips on how to counter misinformation within their communities. The assets were designed to be shared via WhatsApp and Facebook community groups, as well as Twitter, YouTube, and Instagram, to tackle false information spread through private channels.

95. ONS data showed that vaccination rates were lowest among those who identified as Muslim, and communication was shared through local Muslim health professionals and networks to enhance trust and credibility in the vaccination programme and messaging, and address concerns around the vaccines breaking fasts. These included advertising multi-lingual messages on local faith-based community radio stations, increased visibility in the mainstream media of vaccinations being delivered in places of worship, and advertising vaccine information in Eid magazines and Ramadan timetables that were developed at regional and local levels.

96. The concept of family vaccinations, which I promoted within government, was also reflected in communications issued by the NHS to support vaccine uptake during Ramadan 2021, and content was provided and sponsored through the local council of

mosques (or equivalent) and delivered coordinated daily messages and Friday sermon campaigns. Other activities included a series of videos with Dr Amir Khan, a GP from Yorkshire, whose video on the vaccine being halal reached more than 330,000 people.

Development of therapeutics

97. I had no involvement in the development of therapeutics.

Lessons Learned

98. My final quarterly report set out 17 recommendations, all of which were accepted by the then Prime Minister. These included a number of recommendations based on lessons learned from the Covid vaccination programme including:

    a. The government and health agencies must build on the success of the COVID-19 vaccination deployment programme in reaching ethnic minority groups and apply this to future vaccination programmes, including COVID-19 booster vaccinations, winter flu vaccination and childhood immunisation programmes.

    b. Government departments, their agencies and the NHS must continue to build trust in health services within ethnic minority groups through optimising and building on the local partnerships and networks established under the vaccination programme.

    c. The successful elements of the vaccination programme must also be applied to the work to tackle longer-standing health disparities. This must be a priority for the new Office for Health Improvement and Disparities and its partners.

    d. To build confidence in future vaccination schemes and other health interventions, the National Institute for Health Research and the NHS Race and Health Observatory should seek to increase ethnic minority participation in clinical trials and research through methods such as promoting the INCLUDE Ethnicity Framework.

    e. The findings and recommendations from this series of reports should be applied to the government's response to future COVID-19 variants.

f. The government should carry out a review of language and terminology around ethnicity to understand how to target messaging without stigmatising any particular group.

g. The government should use the COVID-19 experience of reaching ethnic minority groups for future public health campaigns. This should include activities to:

    i. Develop and provide materials in multiple languages and formats, including BSL, easy read and audible formats, to ensure content addresses any difficulties to reach diverse audiences,
    ii. Build on community partnerships and work closely with local networks to improve understanding and gain insight into the audience,
    iii. Utilise community partners to co-create content and tailor communications that resonate with key audiences; and
    iv. Communicate key messages through community partners and specialist media and digital channels, using trusted voices to land messaging where necessary.

99. Some of these issues - particularly from a communications perspective - were also considered by the Commission on Race and Ethnic Disparities **[KB/64 - INQ000420906]**, which reported in March 2021. The government's response to the Commission, Inclusive Britain **[KB/65 - INQ000420907]**, was published in March 2022 and sets out a number of relevant actions aimed at closing the trust deficit for certain ethnic minority groups. These actions included commitments to implementing the full set of recommendations from my final quarterly report and for the Equality Hub to lead a review into online misinformation to understand better how different ethnic groups are accessing and interpreting information online.

100. I published update reports in April 2023 **[KB/66 - INQ000420985]** and May 2024 **[KB/67 – INQ000493479]** on the progress we had made in delivering the Inclusive Britain action plan. This included implementing measures such as stopping the use of the term 'BAME' in all government communications and publishing qualitative research into the use of language and terminology relating to people's ethnic identity. The two update reports and Inclusive Britain itself were not subject to findings or reports by Parliamentary bodies or committees.

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: 04/07/2024