Witness Name: Nadhim Zahawi
Statement No: 1
Exhibits: NZ1/1-175
Dated: 22.08.24

UK COVID-19 INQUIRY

WITNESS STATEMENT OF NADHIM ZAHAWI

I, the Rt Hon NADHIM ZAHAWI MP, will say as follows: -

Introduction

1. I make this statement in response to a request from the UK COVID-19 Inquiry (the Inquiry) dated 22 January 2024 under Rule 9 of the Inquiry Rules 2006, asking for a draft witness statement for Module 4 of the Inquiry (ref: M4/Zahawi/01) (the Rule 9 Request).

2. This statement covers the period from 30 January 2020 to 20 June 2022, but it will largely focus on the period between 28 November 2020 and 15 September 2021, when I held the role of Minister for COVID-19 Vaccine Deployment. This is when I had the most involvement in matters falling within the scope of this module, namely the development, procurement, manufacture, approval, delivery and deployment of vaccines, as well as vaccine uptake and safety issues.

3. To address some of the questions sent to me by the Inquiry as part of the request above, I refer to the sixth and eighth statements of Clara Swinson on behalf of the Department for Health and Social Care (DHSC) for this module. My role was, on the whole, to act as an effective CEO; to provide ministerial responsibility for deployment of the COVID-19 vaccine and bridge a gap between Central Government and the Vaccine Taskforce (VTF), which I explain below. Detailed knowledge of how the various moving parts functioned, particularly

within DHSC, was not always central to my role. To avoid repetition, and because I believe DHSC are best placed to provide the foundational information on corporate structures and how and when some decisions were made, I have built upon the information already provided. To date, these statements have been submitted to the Inquiry in draft only, so the paragraphs numbers referred to may be subject to change. 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; and
b) 'DHSC Statement C': The eighth Witness Statement of Clara Swinson.

Background

4. I originally qualified as a chemical engineer and then co-founded an international market research company before becoming the Chief Strategy Officer within the petro-chemical industry.

5. On 13 February 2020, whilst serving as a minister within the Department for Business, Energy and Industrial Strategy (BEIS), under Sir Alok Sharma, I attended a mock pandemic preparation COBR meeting with ministers from Other Government Departments OGDs. The meeting was chaired by the Secretary of State for DHSC and attended by the Chief Executive of the NHS, Simon Stephens, and the Chief Medical Officer (CMO), Chris Witty. All attendees were given a presentation about a hypothetical scenario of the UK being hit by a flu pandemic, showing possible infection and mortality rates and a number of issues that we might be faced with in such a scenario **(NZ1/1 - INQ000479143)**. The meeting took the form of a simulation, with each of us making proposals as to how to manage the crisis and balance the needs of our respective departments, with the central focus being how to protect the NHS and consider the many logistical, political and ethical questions that would inevitably arise in the process. Aside from attending this meeting, I had very little interaction with matters falling within the scope of this module until my appointment as Minister for COVID-19 Vaccine Deployment.

Opening Remarks

6. At the time of my appointment in November 2020, the VTF, which is set out in more detail below, was already a 200 strong organisation. I would like to pay tribute to the many months of work already put into its governance, corporate support and integration within BEIS and in building the relationships with industry and their supply chains. As a result of this hard work, the vaccines had already been sourced and the process for MHRA approval was well underway. Rollout of the COVID-19 vaccines was expected to start in the coming weeks.

7. Although the vaccine project was moving towards rollout, the only way we were able to deliver at pace was by taking a collaborative approach; activities that might have ordinarily taken place separately and successively had to work in parallel. When appointing a minister to bridge this gap between procurement, which had hitherto fallen under the VTF, and deployment, which would rely more heavily on the NHS, it made sense to choose someone from within BEIS with my experience in engineering and business to take an effective 'CEO' role over the already established teams. I believe that one of the Prime Minister (PM)'s strengths was the ability to appoint the right people to the right task quickly. When I received the call from the PM, noting my background, he expressed his confidence in my ability to oversee such a process. I replied to the PM that if I was to succeed in this appointment, I would need his full confidence and be able to work with his authority, the PM understood and gave me the go ahead.

8. The PM also discussed my appointment with the Secretary of State for DHSC, Matt Hancock, with whom I already had a strong working relationship, having co-authored a book together previously, and who, I understand, endorsed my appointment.

9. I think it is fair to say that, at the time of my appointment, there was a perceived lack of confidence following the challenges of Test and Trace and PPE. Central Government was very aware of the need to maintain public confidence and needed to reassure itself and the public that the deployment plan, which was already at a mature stage, was comprehensive and in competent hands. Throughout my time in the post, I would speak to the PM almost every evening to brief him on the progress we had made.

10. I started weekly Zoom calls with all MPs on the 11 December 2020 **(NZ1/2 - INQ000479163)**, as set out in more detail below, these continued beyond my appointment and were an extension of the confidence that I sought to inspire through open dialogue. These calls carried an unexpected but supremely useful benefit in that they yielded local information as to local issues which the constituency MPs were able to relay to my team and me.

11. Ensuring the team was not distracted by external questions formed a large part of my role. I took on the responsibility to keep Central Government up-to-date and informed on progress, this took away the pressure on the team to have to respond to questions from the centre and allowed them to concentrate on the roll out. My team within the VTF assisted me in this way; Emily Lawson, Senior Responsible Officer (SRO) for COVID-19 Vaccine Deployment, led daily vaccine meetings, ensuring I was well briefed to speak with confidence to the Government and media. I was able, in turn, to create the safest, most productive working environment to get the job done. Ms. Lawson is an unsung hero and should be recognised for the vital work she did to get the job done.

12. Transparency of data was also a practice that I championed, to increase public confidence. Vaccination data moved from weekly to daily publication at my insistence. There was, of course, some nervousness in publishing data so frequently, with the risk that small changes or anomalies that might have otherwise evened out would invite criticism and demand careful explanation. I quickly learnt from my first daily press briefings that we could not expect to gain the public's trust without accountability and, with the risk of criticism also came the opportunity to gain valuable insight in real time. In sharing the data openly with the public and inviting questions at daily media briefings, we were, in fact, able to respond to such insights and sharpen our focus to address problems more quickly. It that way, it was the transparency of data, not just its high granularity, which made it such an effective tool to understand and address problems as they arose.

SECTION ONE: OVERVIEW OF MY ROLE AND CORPORATE STRUCTURES

Overview of my role as Minister for COVID-19 Vaccine Deployment

13. On 28 November 2020, alongside the role of Parliamentary Under Secretary of State at BEIS, which I had held since 26 July 2019, I was appointed as Minister for COVID-19 Vaccine Deployment, a joint role between BEIS and DHSC, and remained in the position until 15 September 2021, when I became Secretary of State for Education.

14. Although I remained in my role as a junior Minister within BEIS, taking up the new additional role meant handing much of my former responsibilities to Paul Scully, Minister of State for Small Business, Consumers and Labour Markets. A list of my former responsibilities within BEIS can be found here: **(NZ1/3 - INQ000479249)**. Paul Scully took on responsibilities such as skills, levelling-up, net zero and working on the National Security and Investment Bill **(NZ1/4 - INQ000479223)**. Gerry Grimstone, Minister for Investment, also took on a number of my former responsibilities.

15. I was appointed as Minister for COVID-19 Vaccine Deployment following the success of the 'Ventilator Challenge', on which I worked on behalf of BEIS to help to secure the production of extra ventilation machines to address the anticipated shortage at the start of the pandemic. The near impossible target of 30,000 ventilators in 12 weeks necessitated a creative approach to bureaucracy and logistics, while ensuring the necessary regulatory standards were maintained. My background and skills from working within business and industry really came to the fore in motivating and empowering the team to achieve outcomes under pressure. These skills were crucial to the vaccine deployment project and are likely to be the basis for my appointment. My position within BEIS was also advantageous for the new role; I was able to monitor both supply chain and deployment which I believe was crucial in bringing together the various moving parts of development, procurement and deployment of a safe and effective vaccine.

16. As Minister for COVID-19 Vaccine Deployment, I was appointed to oversee the integration of deployment of the COVID-19 vaccines. In practice, deployment was dependent on supply for its success, so my role often sat between the two. I was effectively a go-between, facilitating the conversation between Central Government and the VTF as well as other

teams from with BEIS, DHSC, NHSE/I, PHE and UKHSA working on all aspects of supply and deployment. I was to report to the Secretary of State for DHSC and directly to the PM at regular intervals.

17. I was put in place to ensure that those within Central Government were kept informed on issues in real time, which included answering to the COVID-19 operations (COVID-O) committee and, in turn, helping to remove administrative and logistical hurdles to the effective deployment of the vaccines. These broadly covered areas such as: vaccine research and clinical trials; vaccine procurement, manufacture, security and supply chain resilience; and vaccine deployment operations, prioritisation and uptake (including public messaging and disinformation) **(NZ1/5 - INQ000479161).**

18. As set out in further detail below, the rollout of the vaccine started within weeks of my appointment in November 2020. My work was, therefore, to operationalise and regularise the work on developing, procuring and deploying vaccines that had been in place since the very early days of the pandemic, when early discussions as to developing a vaccine began.

Division of responsibilities and functions

Overview

19. For an overview of the division of responsibilities and functions in relation to vaccine development and deployment, I refer the Inquiry to paragraphs 29 and 282 to 285 of DHSC Statement A.

Key government and non-governmental bodies

20. For further detail on the key government and non-governmental bodies who worked together with DHSC on vaccines and in relation to matters with the Provisional Outline of Scope for Module 4, I refer the Inquiry to paragraphs 9 to 115 of DHSC Statement A.

Department for Business, Energy and Industrial Strategy (BEIS)

21. BEIS was responsible for securing the supply of vaccines for the UK which included: supporting the research and development of potential vaccines; selecting which vaccines to purchase; securing UK access to sufficient quantities of vaccines; and developing manufacturing capacity to ensure supply. BEIS also worked closely with pharmaceutical companies upon whom we relied to develop potential vaccines.

22. Until August 2021, BEIS supported and held the VTF accountable for securing COVID-19 vaccine supply for the UK, including selecting and buying potential vaccines and developing manufacturing capability. In August 2021, responsibilities for procurement, clinical testing and development moved to DHSC. The background to this decision is set out at paragraph 44 of DHSC Statement A.

Division of ministerial responsibility in my role

23. As set out above, my role often sat between deployment and supply. I was effectively a CEO managing the conversation between Central Government and the various teams working on all aspects of supply and deployment.

24. In the lead up to my appointment, the VTF had been embedded within BEIS, its corporate governance had been built up over the previous months within BEIS and integrated with its established industry relationships and supply chains. Although it had been focussing on procurement and supply, it did have a deployment workstream which had been supporting DHSC in preparation for the rollout.

25. In November 2020, plans were being considered within BEIS for the VTF to become a joint unit across BEIS and DHSC which would take the form of a joint proposal to Simon Case, as set out in the extract above at paragraph 44 of DHSC Statement A, and eventually took place in August 2021.

26. With the shift towards deployment in mind, attaching accountability to one minister who would effectively move with the VTF towards a joint departmental role made sense but required a flexible approach. Although I retained ministerial accountability for vaccine

deployment, the division of responsibilities between me and the Secretary of State for DHSC was, necessarily, increasingly more collaborative. Officially I was to report to the Secretary of State at regular intervals but day-to-day ministerial decisions were often made jointly.

27. I believe our working relationship functioned extremely well. There was a high degree of trust between the Secretary of State for DHSC and me. The fact that we had previously co-authored a book meant we already had a good working relationship. The degree of ministerial cross-over also enabled us to support each other more effectively in a fast-pace, changing environment. This trust was reflected in my team which meant that I was able to release the Secretary of State from much of the day-to-day decision-making and allow him to focus his time on the many other aspects of his role.

Local Government

28. In my experience, there was strong communication between UK Government decision makers and regional local authorities; the role of Local Government was central to vaccination delivery. The building of the large-scale delivery architecture at pace required a particular local knowledge, to identify appropriate vaccination pop-up sites within places of worship, leisure and other community hubs, for example. Local Authorities were essential to the identification of and effective running of both small- and large-scale vaccination sites, relying heavily on local volunteers to support operations.

29. From the beginning of the rollout, we knew that local collaboration was key to the national delivery plan. As an example, discussions with the Secretary of State for DHSC about the Vaccines Delivery Plan in early January 2021 placed great importance in Local Authority involvement and ensuring this approach was accurately reflected in the plan **(NZ1/6 - INQ000479172).** The Ministerial Forward to the Delivery plan, as published on 11 January 2021 **(NZ1/7- INQ000399454)**, provides a useful summary of the approach that was taken:

> *"It is the culmination of months of preparation and hard work by the Vaccine Taskforce, the NHS, Public Health England (PHE), our research institutions and Armed Forces, and local and regional government at every level. International collaboration has been critical. Here at home, we have been putting the architecture*

in place to deliver hundreds of thousands of vaccines per day – from small GP-led sites to large vaccination centres in football stadiums." **(NZ1/7- INQ000399454)**

30. The Vaccines Delivery Plan also contained a section that highlighted the importance of drawing on local authorities' knowledge of their own communities at page 40:

"Drawing on local authorities' knowledge of their communities

Local authorities, working with local NHS colleagues, know their communities best and will play a key role in supporting this, through the expertise of directors of public health and their teams and their wider skills to address diversity and community development. We are committed to ensuring that local authorities and directors of public health have the data they need to understand uptake in their local areas and tailor efforts to reach those who have not yet taken up the vaccine. Local authorities have already been researching the impact of COVID-19 within their communities and we will work closely with them to provide the information they need about COVID-19 vaccines and the vaccine programme to engage actively with communities in the way they feel will work most effectively.

Local authorities leading the way

A number of local authorities are already proactively working in this area, with Hertfordshire County Council leading significant research in this area, published in December 2020 and sharing more widely within the sector. This focuses on 3 Cs:

- *finding ways to reduce complacency regarding the risks of COVID-19*
- *building confidence in the safety and effectiveness of the vaccine*
- *increasing the convenience of being vaccinated*

The national programme is supporting the sharing of this approach and other best practice examples emerging with further webinars hosted to the Local Government Association planned in 2021 for communications and behavioural insight and research teams.

MHCLG is funding the Community Champions Programme which will work with up to 65 local authorities across England to boost work to reach out to ethnic minority and disabled communities. This will include intensive engagement by community voices around vaccinations – learning and other resources from local activity will be shared to a wider audience.

Meaningful community engagement is also being led by local Integrated Care Systems (ICSs) across the country. For example, Devon ICS are working with national advocacy organisation Friend, Families and Travellers to produce a best practice guide to engaging with the traveller community which will include community informed communications and be shared across the country. Building on lessons learnt, Bristol, North Somerset and South Gloucestershire ICS are developing best practice approaches to engaging and supporting people experiencing homelessness, including providing accessible information and supporting GP registration. This is supported and shared nationally through well-established networks of frontline outreach workers and practitioners. These are just 2 examples of community engagement that is going on up and down the country; systems are working hard to engage effectively with their local communities, through established community leaders, such as faith leaders, or by working with local partners to address the concerns and meet the needs of communities." **(NZ1/6 - INQ000479172)**

31. There had been a longstanding concern that vaccine uptake rates within BAME communities, the homeless and other vulnerable groups that cut across JCVI cohorts might be disproportionately impacted. Our problem was lack of data as to what extent and which communities would be the most affected. On 8 January 2021, I asked ministers from DHSC and the Ministry for Housing, Communities and Local Government (MHCLG) to attend a round table to discuss how we could work across Government to ensure these communities are reached **(NZ1/8 - INQ000499497)**. I invited ministers who had been involved with the Test and Trace rollout to see if lessons could be learned in relation to engagement with such harder to reach communities. One such lesson was to be more proactive with Local Authorities and involve them at an early stage, noting that local politicians are incredibly useful in this area and often know which community and faith leaders to talk to. It was also

noted that GPs and community pharmacists are the most trusted health professionals in their community.

32. At the meeting, Dido Harding also raised a point specific to tackling disinformation. It had been her experience that this often circulated in problematic areas, such as Bolton or Oldham, and could be made worse if there was a local distrust of Government or the Local Authority. At the time, there was already early action and engagement with Local Government, but this would have been set against the overall approach to tackling disinformation as set out at paragraphs 190 to 192 below, which was to highlight it as such, then refuse to engage with it. To engage with it was to risk legitimising it. Rather, there was an importance placed on the availability of evidence in support of the vaccine to respond to genuine fears or questions. Part of that approach was to ensure that clinical advice and the scientific basis of policy decisions was shared with the public by national scientists and clinicians, such as: the CMO, the DCMO or Chair of the JCVI, and that information was consistent across the nation. It was important that the sharing of such information was not left to politicians alone, which was particularly important in the above examples of communities that may have a distrust of Government. Where engagement with Local Authorities was key was in the dissemination of that evidence and advice, ensuring the harder to reach communities had access to the right information. To the best of my knowledge, this meeting was the first time that I was aware of this particular issue of localised disinformation. I suspect that earlier knowledge of lessons learned from Test and Trace could have helped us to engage with local networks sooner but even in hindsight, I believe that we too action to engage with local networks quickly and effectively.

33. As a result of this early action, there was strong collaboration with Local Government in the area of vaccine delivery, using community engagement and the knowledge of the Local Resilience Forums to create tailored outreach programmes that would reach all areas of society. This approach is further explored below in the subsection on consideration of vulnerable or marginalised groups in Section Four.

34. I also set out further examples of strong engagement with local authorities, leaders and representatives as part of understanding and addressing disparities in uptake at Section Five.

35. Although much of my engagement with local authorities centred around addressing community disparities in uptake, I was also involved in some direct communications with local leaders to discuss the vaccine rollout. For example, on 10 December 2020, I and other ministers from DHSC and MHCLG made calls to regional representatives to discuss the country's recent return to the regional, tiered approach to lockdown measures and how the timing of the vaccine rollout would complement the Winter plan and help reduce the long-term need for such measures. Within the briefing pack, which formed the basis of discussions, the Government set out headline plans for the vaccination rollout for local leaders, including a distribution map of hospital hubs by region and plans for the GP-led primary care networks to join in vaccination delivery from the following week **(NZ1/9 - INQ000479156**) **(NZ1/10 - INQ000479157)**.

Devolved administrations

36. For a summary of the role of devolved administrations in relation to public health, I refer the Inquiry to paragraphs 112 to 115 of DHSC Statement A.

37. As part of my role, I attended a number of meetings with Devolved Government ministers. I had separate calls with the Ministers for Health for each of the three devolved nations at the start of my appointment in December 2020 to discuss aligning data cycle and release days and any outstanding concerns in coordinating delivery of the first vaccines. I exhibit the readouts for these meetings as follows: Vaughan Gething on 16 December 2020 **(NZ1/11 - INQ000479159)**; Robin Swann on 16 December 2020 **(NZ1/12 - INQ000479160)**; and Jeanne Freeman on 17 December 2020 **(NZ1/13 - INQ000479162)**. These meetings were a positive start to the strong, collaborative working relationship that was built between the UK Government and Devolved Governments.

38. In the evening prior to the meeting with Vaughan Gething, Emily Lawson was told by her Sottish counterpart that they were planning on publishing some vaccine deployment data for Scotland first thing in the morning. As a result, there was a need to coordinate figures from the devolved nations to establish accurate UK wide figures which could be published simultaneously and ensure that the Scottish figures could be accurately reflected as part of

the whole. This was discussed with all the Devolved Administrations' communications leads and it was agreed that UK wide figures would be published by way of a press release close to midday, in line with Scotland's plans to publish their own figures. The headline national figures were released with the more detailed breakdown promised as part of a more formal weekly statistical bulletin planned for 24 December 2020 **(NZ1/14 - INQ000499494)**.

39. Although deployment was a devolved issue, the delivery of the vaccine to each nation with varying population density and landscape was also an issue that demanded a collaborative approach. On 29 November 2020, I approved a Memorandum of Understanding (MOU) which addressed a geographical hurdle to delivery of the vaccines specific to Wales and the number of remote locations where they would be deploying a vaccine as part of their 'first wave' of deployment **(NZ1/15 - INQ000479012) (NZ1/16 - INQ000479010) (NZ1/16a - INQ000479146).** The delivery of the Pfizer/BioNTech vaccine created a unique challenge for Wales, given the number of 'transitions' (move from one ultra-low-temperature environment to another) required during its entire journey. Wales, therefore, requested that they take direct delivery of the vaccine from the supplier rather than via PHE, which required an MOU to clarify roles and responsibilities around the point of hand-off of the vaccine.

40. In my opinion, the Devolved Governments were appropriately involved in not just the core decision making but in managing the effective alignment of the deployment of the vaccine between the four nations of the UK as set out in the subsection on Devolved Administrations in Section Four below.

Key decision-makers

41. A list of key decision-makers in DHSC in respect of the topics outlined in the Provisional Outline of Scope for Module 4 was provided to the Inquiry by DHSC on 10 November 2023 **(NZ1/17 - INQ000399472)**. In relation to the Ministers and decision-Makers from within DHSC, NHSE and the VTF, those mo involved in vaccines are set out at 38, 120 to 124, and 284 of DHSC Statement A.

42. In relation to decision-making within the VTF, the chair of the Taskforce reported directly to the PM and was not accountable to BEIS or DHSC. Although the overall direction and

strategy is set by the chair, supporting delivery of the VTF's objectives were various groups set up by BEIS, including:

a) the VTF steering group: chaired by the chair of the VTF and with a team of directorates as set out below, to oversee delivery of the VTF, and provide oversight of policies and strategies **(NZ1/17a - INQ000234621);**
b) an Expert Advisory Board: chaired by the Chief Scientific Advisor to act as a sounding board and provide expert advice on the development and implementation of the actions of the Taskforce, and to champion and guide activities taking place across government, academia and industry to accelerate the development and manufacture of a COVID-19 vaccine **(NZ1/18 - INQ000234369**);
c) a Programme Board: chaired by the Taskforce's senior responsible owner to develop and deliver the Taskforce's programme, and to act as the principal decision-making body which provides the Government with oversight of the Taskforce's activities.

43. Without exception, the members of the VTF were strong and determined individuals to whom this country owes a great debt. They gave of themselves without pause and drove the programme working together as a highly effective team. I will be forever proud of the work we did together and we should all thank every one of them.

44. The VTF interim report, published in December 2020 (now withdrawn) sets out the members of the VTF Steering group as follows:

a) Kate Bingham, VTF Chair (later to be replaced by Sir Richard Sykes);
b) Clive Dix PhD, VTF Deputy Chair;
c) Nick Elliot MBE, Director General;
d) Ruth Todd, Director;
e) Madeleine McTernan, Director;
f) Tim Colley, Director;
g) Dan Osgood, Director;
h) Divya Chadha Manek, National Institute for Health Research (NIHR);

i) Ian McCubbin OBE, Manufacturing Advisor;
j) Steven Bates OBE, Chief Executive Officer, BioIndustry Association (BIA);
k) Professor Jonathan Van-Tam MBE, Clinical and public health Advisor to the VTF, DCMO.

45. In March 2021 a power point presentation was prepared to illustrate how each of the directors within the VTF functioned under the leadership of Director General and SRO, Madeleine McTernan **(NZ1/19 - INQ000479225)**. At our daily vaccines meetings, we would hear from the directors from each part of the team, so I was always kept up-to-date on how each area of the VTF was functioning. I summarise their roles and responsibilities as set out in March 2021, as follows:

a) Ruth Todd, Operations Director.
   i. Responsibilities: portfolio management oversight of day-to-day manufacture and supply including delivery and security. Ruth Todd was responsible for AstraZeneca and Pfizer/BioNTech.
b) Steve Glass, Programme Director.
   i. Responsibilities: portfolio management oversight of day-to-day manufacture and supply including delivery and security. Steve Glass was responsible for all vaccines in the portfolio aside from AstraZeneca and Pfizer/BioNTech.
c) Dan Osgood, Strategy Director.
   i. Responsibilities: domestic vaccines strategy and policy; VTF legacy, commercial and comms.
d) Tim Colley, International Director.
   i. Responsibilities: driving the new international initiative for vaccine procurement via COVAX, to deliver equitable global access and strengthen the global system to respond to future pandemics.

46. Other Ministers and officials within BEIS, further to those referenced above, relevant to the VTF and my work on vaccines as follows:

a) Secretary of State for Business, Energy and Industrial Strategy – Rt Hon Sir Alok Sharma KCMG MP (13 February 2020 and 8 January 2021);

b) Secretary of State for Business, Energy and Industrial Strategy – Rt Hon Kwasi Kwarteng MP (8 January 2021 – 6 September 2022); and
c) Parliamentary Under Secretary of State Minister for Science, Research and Innovation – Amanda Solloway MP (14 February 2020 and 8 July 2022).
d) Permanent Secretary and Principal Accounting Officer – Sarah Munby
e) Director General for Science Innovation and Growth – Jo Shanmugalingam
f) Scientific Adviser – Professor Paul Monks

Transfer of the role of Minister for COVID-19 Vaccine Deployment

47. The role of Minister for COVID-19 Vaccine Deployment, and much of the ministerial responsibility that came with it, was created with my appointment. Although Rt Hon Jo Churchill had, in her role as parliamentary Under-Secretary at DHSC, started work on vaccine deployment, this was at a very early stage. There was, therefore, very little transfer of ministerial responsibility when I took on my joint role between DHSC and BEIS. I do not believe there were any issues during handover that impacted on the COVID-19 response. Jo Churchill would also have had to take on new responsibilities with her new role. She remained in her ministerial position at DHSC until 15 September 2021 when we were both appointed to another department.

48. Outside of the duties that had largely been created with the role, there were a number of ministerial responsibilities that I took on that would have been appointed, on the whole, to the Secretary of State for DHSC such as communication with the Devolved Administration in respect of planning the roll-out. In relation to ministerial responsibility for the planning or implementation of measures designed to achieve vaccine uptake among groups with historically lower rates of uptake, I believe this would have been allocated to the then Minister for Equalities, Kemi Badenoch MP. In December 2020, I was copied into a letter that she wrote to Professor Wei Shen Lim, bringing to his attention some of the findings from her own work on COVID-19 disparities experienced by individuals from an ethnic minority background. She also highlights the need for good vaccine uptake and coverage in ethnic minority groups, greater efforts in communication strategies to tackle misinformation **(NZ1/20 - INQ000499490) (NZ1/21 - INQ000083875)**.

49. It should be noted that my appointment as Minister for COVID-19 Vaccine Deployment followed the success of the 'Ventilator Challenge', on which I had already worked to secure the production of extra ventilation machines at the start of the pandemic. This work was complimentary to my new role and assisted in what felt to me as a natural transition.

50. The change in ministerial positions in September 2021 also occurred at a time that had very little impact on the deployment of vaccines and the COVID-19 response more generally. By the end of October 2021, most of the vaccine rollout objectives had been met and the VTF had contracts or agreements for more than 340 million doses of vaccine to be delivered to the UK by the end of 2022 (including those already used). There were, in my opinion, no real issues during the handover to Rt Hon Maggie Throup MP. The rollout was moving to its final stage and the structures that held it in place were established and had been functioning well. I do not believe that formal ministerial continuity would have had any real impact on the trajectory of the last stage of the rollout. In short, I felt that my work was done. When I was asked to take on the role of Secretary of State for Education, a department that was also subject to severe disruptions from the pandemic, I was happy to accept the new challenge.

Key decisions

51. Throughout this statement, I refer to timelines of relevant advice and subsequent decisions made within each topic, as taken from the DHSC Statement A. For ease, I set out the relevant sections below:

    a) The development and approval of vaccines (paragraphs 140 to 168);
    b) JCVI advice (paragraphs 197 to 280);
    c) The Moral and Ethical Advisory Group (MEAG) advice (paragraph 111) within the section on the MEAG; and
    d) Vaccine Deployment Programme (paragraph 281 to 301).

52. Further to the above, I set out the following chronology of key dates, relevant to my involvement in matters falling within the scope of this module:

a) In early April 2020, the VTF was set up within BEIS, although I did not become a member until my appointed as Minister for COVID-19 Vaccine Deployment in November 2020.

b) On 28 April 2020, I, along with several ministers from BEIS and DHSC, agreed to the term sheet from AstraZeneca and that they should announce their collaboration with the University of Oxford, which they proceeded to announce on 30 April 2020 **(NZ1/22 - INQ000234353)**.

c) On 28 November 2020, I was appointed as Minister for COVID-19 Vaccine Deployment.

d) On 29 November 2020, I approved an MOU with Wales in relation to the delivery of the Pfizer/BioNTech vaccine **(NZ1/16a - INQ000479146) (NZ1/17-INQ000399472) (NZ1/17a - INQ000234621)**.

e) In December 2020, Richard Alcock was appointed as SRO for Vaccine Security and the UK COVID-19 Vaccine Security Team (UKCVS) was set up.

f) In December 2020, the Secretary of State for DHSC and I approved the publication of an interim report on the VTF to outline the progress made by the VTF (now withdrawn) **(NZ1/23 - INQ000479155)**.

g) On 4 December 2020, I approved the process for notifying Parliament of the future contingent liability of the Pfizer/BioNTech vaccine, following MHRA approval **(NZ1/24 - INQ000059410).**

h) On 11 January 2021, the UK COVID-19 Vaccines Delivery Plan was published, for which I produced a ministerial foreword jointly with the Secretary of State for DHSC **(NZ1/07 - INQ000399454).**

i) On 22 January 2021 and 25 January 2021, the Secretary of State for DHSC and I agreed the approach suggested for resolving decisions about Phase 2

prioritisation and seeking further advice from JCVI and MEAG, given the identified unknowns from Phase 1 **(NZ1/25 - INQ000401330) (NZ1/26 - INQ000479185).**

j) On 28 January 2021, at a Small Ministerial Group (SMG) meeting with the Secretary of State for DHSC and the Chancellor, we agreed that the approach to Phase 2 should align with the overarching priority of further reducing mortality, morbidity and hospitalisations. We agreed to take advice from the JCVI on the best strategy to achieve this **(NZ1/27 - INQ000401333**).

k) On 9 February 2021, I attended a COVID-O meeting where we agreed with the SMG decision above; that the approach to Phase 2 should align with the overarching priority of further reducing mortality, morbidity and hospitalisations. We agreed to take advice from the JCVI on the best strategy to achieve this **(NZ1/28 - INQ000091773)**.

l) On 13 February 2021, the Vaccine Uptake Plan was published, for which I produced a ministerial foreword jointly with the Secretary of State for DHSC **(NZ1/29 - INQ000234748)**.

m) On 24 February 2021, I approved a submission on the approach to be taken on vaccinating HMG staff living overseas **(NZ1/30 - INQ000479210)**.

n) On 26 February 2021, the JCVI published the interim advice as sought at the SMG meeting above which recommended an age-based approach to Phase 2 prioritisation **(NZ1/31 - INQ000354488)**, which the MEAG subsequently supported at a meeting on 3 March 2021 **(NZ1/32 - INQ000401396)**.

o) On 12 April 2021, the Secretary of State for DHSC and I agreed to the publication of the JCVI final advice on Phase 2 **(NZ1/33 - INQ000499504)**.

p) On 15 April 2021, the Secretary of State for DHSC and I agreed to allow the updated recommendation from the JCVI to offer routine vaccination in pregnancy to be made public via an update to the Greenbook **(NZ1/34 - INQ000111012)**.

q) On 5 July 2021, I agreed to recommendations based on clinical advice that the Government should reduce the dose interval to 8 weeks and no lower for all age groups and all vaccine brands **(NZ1/35 - INQ000401356) (NZ1/36 - INQ000234938) (NZ1/37 - INQ000479239)** which was announced by the Government on 5 July 2021 to ensure the strongest possible protection from the Delta variant.

r) On 22 July 2021, the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021, gave effect to the Vaccine as a Condition of Deployment (VCOD) policy.

s) In August 2021 the VTF became a joint unit between BEIS and DHSC.

t) In early August 2021, I set up the Vaccine Uptake Taskforce which had its first meeting on 4 August 2021.

u) On 15 September 2021, my role as Minister for COVID-19 Vaccine Deployment came to an end, when I became Secretary of State for Education.

v) On 16 September 2021, Maggie Throup MP appointed was Minister for Vaccines and Public Health within DHSC.

w) On 11 November 2021, the VCOD policy came into effect.

Reports and Reviews

53. As set out above, in December 2020, the Secretary of State for DHSC and I approved the publication of an interim report on the VTF to outline the progress made by the VTF (now withdrawn) **(NZ1/23 - INQ000479155).**

54. I also gave evidence on 10 March 2021 to the Women and Equalities Committee on the Government's approach to the vaccination of the BAME communities and women **(NZ1/38 - INQ000479218).**

SECTION TWO: VACCINE DEVELOPMENT

My work within BEIS prior to Minister for COVID-19 Vaccine Deployment

55. Although the VTF was set up in April 2020 within BEIS, my role at the time within BEIS was concerned with the Ventilator Challenge. At paragraphs 158 to 160 of his Third Statement to the Inquiry, dated 29 March 2023, Sir Christopher Wormald summarises the work of the Ventilator Challenge, on behalf of DHSC, as follows:

56. In response to the immediate need for more mechanical ventilators, the Government developed a cross-departmental approach across the following three workstreams:

    a) increased purchasing of existing ventilators available to the NHS (this was led by the Department/NHSEI under the National Covid Oxygen, Ventilation, Medical Devices & Clinical Consumables (02VMD&CC) Programme) **(CW3/392 - INQ000106555);**

    b) ramping up the manufacture of existing ventilator designs (led by CO); and

    c) partnering designers with large manufacturers to rapidly develop and manufacture new simplified ventilator designs (led by CO).

57. Workstreams b. and c. detailed above became known as the 'Ventilator Challenge' **(CW3/392 INQ000106555 to CW3/395 INQ000106519)**. The Department and the CO ran their programmes separately but worked towards the same overall targets and exchanged data on their progress in acquiring ventilators daily.

58. In March 2020, the NHS had around 7,400 mechanical ventilators. Modelling based on the trajectory of other European countries forecast the need for significant and extremely rapid increases in the UK ventilator capacity and the Government adopted a formal target to secure up to 30,000 ventilators by 30 June 2020. The Ventilator

Challenge began on Friday 13 March 2020 with CO inviting a number of organisations to take part in the project, followed by a "call to arms" to industry bodies by the Prime Minister on 16 March 2020. By 30 April 2020, the total number of ventilators available to the NHS had increased to 1 1 ,500 and by 30 June 2020 it stood at around 24,000 (of which around 12,000 had been built via the Ventilator Challenge). The Department and CO met the 30,000 target in early August 2020.

59. The Ventilator Challenge was led by the Cabinet Office (CO), but there were key activities undertaken by BEIS on specification, shortlisting offers to support the building and testing of ventilation devices, and the management of relationships with partners. My role on behalf of BEIS involved the coordination of manufacturers willing to address the issue of our ventilator shortage. My department was under the management of Dick Elsy, an engineer who ran the High Value Manufacturing Catapult for the Government, a non-profit, independent organisation that promotes and supports the research and development of new products.

Early COVID-19 Vaccine Development

60. At the start of my appointment in November 2020, my work was, in the large part, to operationalise and regularise the work on developing, procuring and deploying vaccines that had been in place since the very early days of the pandemic, when early discussions as to developing a vaccine began. Although I did not work directly on the development of vaccines until my appointment as Minister for COVID-19 Vaccine Deployment, I feel it is important, for context, to summarise the groundwork that had been laid as well as the corporate structures that already existed prior to my appointment.

61. Key to the success of the vaccine programme was the very early acceptance by DHSC that vaccines would take us out of the pandemic. This meant that DHSC had started preparatory work for a vaccine in January 2020, this is set out at paragraphs 21 to 22 of DHSC Statement A.

62. DHSC continued to support the Government in planning for and delivering a successful vaccination programme in response to COVID-19. Early in the pandemic, and prior to the establishment of the VTF, DHSC was also supporting early vaccine research and clinical

trials and working with OGDs to set out a strategy for deployment, should one of the vaccine candidates eventually be deployed. In my view, one of the most important early decisions was to sponsor a number of research teams' work to develop a vaccine; this meant that the UK was not reliant on one laboratory but many; this is why when we started the vaccine rollout we had more than one vaccine available.

The Vaccine Taskforce (VTF)

63. As set out in DHSC's review of the VTF in August 2023 (the VTF Review) **(NZ1/39 - INQ000399474),** the VTF was set up within BEIS in April 2020 with three objectives:

    1. Secure access to promising vaccine(s) for the UK population and achieve lasting immunity.
    2. Make provision for international distribution of vaccines.
    3. Strengthen the UK's onshore capacity and capability in vaccine development, manufacturing and supply chain to provide resilience for this and future pandemics.

64. As identified in the review, there was a great deal of work undertaken by the VTF leading up to the heads of terms being agreed for 7 vaccine deals by November 2020:

    "In the early days of the pandemic there were believed to be approximately 200 COVID-19 vaccines in early development stage across the world. The chances of any one vaccine candidate being effective and safe were remote, owing to the traditionally lengthy and trial and error approach to the activity in 'normal' times, which various estimates suggest can take 10 years from the early research and development (R&D) to regulatory approval and mass manufacture of a successful vaccine. The VTF's own programme business case quantified the likelihood of any individual vaccine being safe and effective as between 5% (pessimistic scenario) and 10% (optimistic scenario). This range was based on advice from the VTF's specialists in vaccine development. The VTF's early priority was therefore to set out to secure a portfolio of promising vaccine candidates, increasing the overall likelihood of finding at least one safe and effective vaccine.

VTF's direct approach was to evaluate the around 200 global candidates and secure access to a portfolio from these. The VTF assembled a vaccines due diligence team, made up of clinical, scientific and industry experts, to narrow down this large field. The first step was to rule out any vaccine that had no realistic chance of entering clinical trials in 2020, as its route to deployment, if safe and effective, would simply be too long.

Another key early principle was that the VTF wanted to secure access to vaccines across a range of development modalities (as in vaccine platforms), rather than back one type of technology above all others. This would later prove key, as the VTF's backing for more novel technologies (notably mRNA vaccines) over traditional ones proved to be the correct approach. The VTF due diligence team performed detailed data analysis of the remaining candidates.

The method to securing these contracts was based on treating each as a bespoke deal, rather than approaching each as a standardised procurement activity. This recognised that every developer had a unique product that was potentially the only successful vaccine and allowed the UK to tailor each deal accordingly.

This speed and quality of analysis, supported by a commercial mindset to deal-making, allowed the UK government to move at speed to secure its vaccine portfolio, and heads of terms agreements for all 7 deals were signed by mid-November 2020." **(NZ1/39 - INQ000399474)**

65. The review also explains the purpose and scope of the taskforce, how its objectives evolved over time, key facts and figures and a review of progress against the VTF's objectives, which were firstly to secure access to promising vaccine(s) for the UK population and achieve lasting immunity and secondly to make provision for international distribution of vaccines. **(NZ1/39- INQ000399474)**:

"In early April 2020, the Vaccine Taskforce (VTF) was set up in BEIS to gather together the collective efforts of government, academia and industry to help find a vaccine against COVID-19, to protect and save the lives of UK citizens.

The VTF was established in BEIS with a steering group comprising both external experts and senior civil servants, initially chaired by Dame Kate Bingham until December 2020 and subsequently by Clive Dix, followed by Sir Richard Sykes. The VTF consisted of:

- *A strategy directorate;*
- *An international directorate;*
- *A commercial directorate (to lead negotiations with suppliers); and*
- *A programmes directorate (to oversee the day-to-day delivery of the agreements the VTF made).*

The VTF mobilised and recruited staff from across the Civil Service, private sector and academia. This provided a breadth of expertise, ranging from clinical and scientific knowledge, through to supply, programme management, delivery and commercial.

The VTF's formal accountability was through the usual Civil Service procedures. A ministerial panel took all key spending decisions. The panel was made up of the:

- *Health and Social Care Secretary;*
- *Business Secretary;*
- *Chief Secretary to the Treasury;*
- *Minister for Government Efficiency at the Cabinet Office.*

Day-to-day ministerial decisions were taken by the Secretary of State and/or Business Secretary, with assurances sought and provided in the usual way, by permanent secretaries and/or accounting officers. The Director General of the VTF was the Senior Responsible Officer of the programme throughout.

In July 2020, the VTF agreed a £5.2 billion programme business case with HM Treasury, supported by funding from the reserve, to fund interventions to help the VTF meet its objectives. At the start of the pandemic, the chances of a single vaccine being found to be safe and efficacious against COVID-19 in the near term were widely

believed to be slim: the VTF itself quantified the optimistic scenario of a vaccine proceeding from the pre-clinical phase through to full safety and efficacy as a likelihood of 10%. Therefore, right at the heart of the VTF's efforts to meet its objectives was a portfolio approach to vaccine procurement - increasing the overall chances of finding a single successful vaccine through multiple 'shots on goal'." **(NZ1/39- INQ000399474)**

Overview of my role within VTF and in the development and procurement of a vaccine

66. By the time I was appointed in November 2020, the vaccines had been sourced and the process for MHRA approval was well underway. The table below, taken from the VTF Review, shows the UK vaccine portfolio at December 2020:

Vaccine	**Date**	**Original doses secured bilaterally (millions)**	**MHRA approved**	**Deployed in the UK**	**Additional information**
Oxford AstraZeneca	17 May 2020	100	Yes (2 December 2020)	Yes	Contract completed (50 million deployed and 50 million donated)
Sanofi-GSK	29 July 2020	60	Yes (21 December 2022)	Yes (spring 2023)	Order reduced to 7.5 million doses November 2021
Janssen	14 August 2020	30	Yes (28 May 2021)	No	Order reduced to 20 million doses and donated May 2021
Moderna	16 November 2020	17	Yes (8 January 2021)	Yes	60 million extra doses secured December 2021, to cover 2022 and 2023 deployment
Novavax	14 August 2020	60	Yes (3 February 2022)	Yes	Further 14.7 million doses ordered through COVAX donated. Bilateral 60 million dose order reduced to 1 to 16 million doses in July 2022
Pfizer-BioNTech	20 July 2020	40	Yes (2 December 2020)	Yes	Further 500,000 doses ordered through COVAX. 60 million extra doses

					secured April 2021 for primary and booster campaigns. 35 million extra doses secured in August 2021 for autumn booster campaign. 54 million extra doses secured December 2021, for 2022 and 2023 deployment
Valneva	14 September 2020	60	Yes (14 April 2022)	No	Contract terminated September 2021

67. In December 2020, the Secretary of State for DHSC and I approved the publication of an interim report on the VTF to outline the progress made by the VTF, OGDs and industry partners, centred around its three main objectives outlined above **(NZ1/23 - INQ000479155).** The diverse vaccine portfolio in December 2020, as reflected in the table above, was a reflection of the strategy to build a balanced portfolio with different proven and unproven vaccine types to allow the VTF to engage broadly with the industry and academic community, generate new opportunities and maximise the chance of success.

68. The report noted that the VTF's focus was to secure access to the most promising vaccines likely to be safe and effective with the highest confidence of early approval and delivery to the UK. This meant more time to make the necessary plans for deployment and secure essential equipment to manage the cold chains and complex vaccination programme.

69. Although the decision not to participate in the EU joint procurement on vaccines was taken before my appointment, I think it important to note that the report set out its reasons for doing so in broad terms, as follows:

> *"...it would not have been possible for the UK to have a say in decisions such as vaccine choice or key contract terms. It would also not have been possible for us to participate whilst also pursuing negotiations with individual vaccine suppliers. However, we continue to work with the EU on our shared international goal of accelerating global vaccine access to end the pandemic, for example the EU and UK*

co-hosted the launch of the ACT-Accelerator and we are both supporting the COVAX initiative as participants and donors." ***(NZ1/39A -*** **INQ000128474)**

70. The groundwork was being laid for manufacture, supply and deployment, but needed constant care, attention and support to make it work. At the time, the expertise and knowledge within BEIS and the VTF was seen as essential in supporting the NHS to coordinating deployment. Ongoing project management and contact management of suppliers and their supply chains was critical to deployment and something that did not typically fall within the expertise of the NHS who were used to purchasing medicines as commodity items. I was brought in to focus on the integration of deployment, especially within the health family and to provide single ministerial accountability. I was building on the excellent work of Kate Bingham, who was still chair of the VTF for the first few weeks of my appointment.

71. On 27 January 2021, I attended a VTF manufacturing meeting with the minister for Technology, Innovation and Life Sciences, Lord Bethell, and members of the VTF, to address one of the taskforce's key goals: UK resilience in vaccine supply. It was agreed that further such manufacturing meetings should take place monthly **(NZ1/40 - INQ000479196).** It was agreed that a manufacturing strategy should focus on onshoring. The group also agreed with my proposal that it should be focussed on the short, medium and long term as follows:

    a) Immediate need (short term) – capitalising relationships and existing contracts, including Valneva and AstraZeneca. The aim is to vaccinate the nation and to ensure we have some resilience in the system.
    b) Medium term – building the Vaccine Manufacturing Innovation Centre (VMIC) and scaling up other manufacturing opportunities.
    c) Long term – searching for broader investment opportunities to bring manufacture to the UK.

72. I am aware that a decision was taken in November 2021 to sell VMIC. This decision was taken outside my tenure as Minister for COVID-19 Vaccine Deployment, so I was neither partial to the reasons behind the decision nor any consideration of the impacts of the sale.

The last engagement I had with VMIC was on 23 July 2021 during my visit to the Harwell campus **(NZ1/41 - INQ000499507).**

73. I set out the following examples of further manufacturing meetings at which I was in attendance:

    a) On 9 February 2021, we focussed on the VTF's long term manufacturing strategy and how this must go beyond pandemic preparedness **(NZ1/42 - INQ000479203).**
    b) On 26 April 2024, with the Secretary of State for DHSC also in attendance, we discussed a presentation on UK resilience in vaccine supply which the VTF were due to present at the Vaccines, Antivirals and Therapeutics Strategy Board **(NZ1/43 - INQ000479229).** I encouraged the team to think entrepreneurially in relation to strengthening the UK's onshore capacity by building healthy commercial relationships between partners, such as VMIC and Curevac **(NZ1/44 - INQ000479230).**

    As with the example above, I often tell my teams to think entrepreneurially; the aim is to minimise mistakes but, if you are fixated on the avoidance of criticism, your output will be correspondingly narrow.

74. I sat on the Ministerial Panel, as mentioned in the DHSC report above, which took all key spending decisions for the VTF. The Ministerial Panel met 11 times. I became a member from the start of my appointment and therefore attending meetings from 18 December 2020:

    a. 27 August 2020 **(NZ1/45 - INQ000401292)**
    b. 11 September 2020 **(NZ1/46 - INQ000401294)**
    c. 6 October 2020 **(NZ1/47 - INQ000479144)**
    d. 22 October 2020 **(NZ1/48 - INQ000401300)**
    e. 16 November 2020 **(NZ1/49 - INQ000401303; NZ1/50 - INQ000401304)**
    f. 18 December 2020 **(NZ1/51 - INQ000401309)**
    g. 31 December 2020 **(NZ1/52 - INQ000401325)**
    h. 12 January 2021 **(NZ1/53 - INQ000401328)**
    i. 28 January 2021 **(NZ1/54 - INQ000479894)**

j. 11 March 2021 **(NZ1/55 - INQ000401343)**

k. 29 March 2021 **(NZ1/56 - INQ000401346)**

75. From August 2021 the VTF became a joint unit between BEIS and DHSC. While BEIS remained accountable for the VTF's work to support onshoring of vaccine capability, DHSC became responsible for procurement, clinical testing, and planning how to administer the vaccine to the public in England. Establishing the VTF as a joint unit between the two departments reflected the strong link between procurement and deployment and was, in my opinion, an appropriate move. On 15 September 2021, my role of Minister for COVID-19 Vaccine Deployment was therefore no longer held within BEIS and instead the role of Minister for Vaccines and Public Health was created within DHSC, to which Maggie Throup MP was appointed on 16 September 2021.

76. The VTF operated well under the leadership structure which divided up its functions between its directors, as set out above at paragraphs 41 – 46. Each had a distinct role according to their expertise but with effective communication between all the moving parts, for example at our daily vaccines meetings, when we would hear from directors from each part of the team. The leadership structure was well established by the time of my appointment. As the team moved towards the rollout, it was the opportune moment to coordinate both procurement and deployment under one minister. In my view, the team adapted well to my appointment and benefitted from the clear line of ministerial accountability.

Collaboration between the public and private sector: development, manufacture, procurement, and approval

77. For a more detailed background as to how the VTF went about securing its vaccine portfolio, which happened largely before my appointment as Minister for COVID-19 Vaccine Deployment, I refer the Inquiry to the VTF Review. The focus on private sector collaboration, and the £500 million subsequent investment procured, is seen as one of the key factors for the VTF's success. Specific achievements of this collaborative approach are noted in the review as follows:

"The VTF has utilised the collective expertise of an array of specialists, including from within the Civil Service and wider public sector to achieve its objectives. Examples include:

- *private sector expertise: senior leaders from industry were recruited to the VTF Steering Group, including Dame Kate Bingham as Chair in 2020, and Sir Richard Sykes, Chair from 2021 to 2022*
- *commercial: deal-making expertise was mobilised from elsewhere in government to lead the negotiations and commercial strategy*
- *programme delivery: experienced leaders with extensive delivery expertise garnered in the public and private sectors were mobilised to the VTF*
- *manufacturing: working closely with industry experts, both in an advisory capacity, and through formal secondment to working level teams, the VTF developed an early manufacturing strategy*
- *clinical trials: alongside DHSC, NIHR and the MHRA, the VTF was able to deliver on the priority to support the rapid delivery of clinical trials through, for example, making the UK an attractive place for vaccine developers to trial their products, and manufacturing these products, where applicable*
- *science in decision-making: the VTF has drawn on expertise across government (including UKHSA,DHSC and JCVI) and in academia to ensure its decision-making on procurement is always informed by the latest scientific and clinical advice. For instance, on issues such as vaccine effectiveness and durability, and the evolution of the disease (including variants of concern)."* **(NZ1/39 - INQ000399474)**

78. I agree with the findings of the report and consider the above an accurate reflection of some of the best ways in which we collaborated with the private sector to achieve our aims. In particular, I found the private sector expertise within the leadership of the VTF itself to be crucial to its success. Individuals like Kate Bingham, with her experience as a venture capitalist, specialising in healthcare, brought an entrepreneurial approach to the precuring of a viable vaccine. The high stakes could well have stunted decision making within the VTF, but Kate Bingham and other senior leaders from industry came from a background that

relied on risk taking and creativity. As I have already said above, in my experience in politics, the fear of exposure to public criticism can often be an obstacle; we needed, and what we had, were individuals from the private sector who were robust and highly experienced in rolling out and running what was, in effect, a complex organisation.

My role in the contractual arrangements entered into by the UK Government

79. As to the contractual arrangements entered into by the UK Government with each developer, manufacturer or supplier, any active role I played in these fell largely within the period of my appointment as Minister for COVID-19 Vaccine Deployment. My background within BEIS and my Life Sciences ministerial role helped prepare me for negotiations and, when negotiating with AstraZeneca in particular, I was able to draw on my experience on the Business, Innovation and Skills Select Committee from as far back as 2014.

80. In 2014, during its proposed hostile takeover of AstraZeneca, the CEO of Pfizer/BioNTech came before the Business, Innovation and Skills Select Committee. AstraZeneca is one of the most valuable British companies and I am pleased it was able to maintain its independence. Pascal Soriot, CEO of AstraZeneca, was particularly thrilled with the outcome and when I called to discuss vaccines with him, I was pleased to hear he remembered me. He believed that the work we had done at BEIS had helped save his company and was eager to work with me again.

81. As a result of the fast-tracked regulatory approval process, Pascal and the board agreed that AstraZeneca would provide their vaccine at cost during the pandemic. This was a far-reaching decision for the UK. AstraZeneca would go on to make a profit after the pandemic, making the deal mutually beneficial, but I do not believe we would have been in the position to procure so many doses of the vaccine so quickly without the good faith of our historic relationship and this country's investment in scientific research and development.

82. On 4 December 2020, I approved the process for notifying Parliament of the future contingent liability of the Pfizer/BioNTech vaccine, following MHRA approval. This would be in the form of a Written Ministerial Statement (WMS) and Departmental Minutes, as required by HMT **(NZ1/57 - INQ000340135).** These set out the scope of the indemnities included in

the contracts to procure COVID-19 vaccines by HMG on behalf of the entire UK (including Devolved Administrations) and also for Crown Dependencies and Overseas Territories.

83. This followed the approval by HMT to waive the usual 14-day notice period usually given to Parliament, and to notify Parliament using a letter to the PAC and relevant Select Committees of the future contingent liability. The 14-day wait was also waived in relation to the formal public notification, but WMS and Departmental minutes were required for each vaccine, ideally before vaccination commenced, but this was not a requirement.

84. While much of the negotiations as to vaccine contracts and subsequent indemnities had already been carried out before my tenure, I was aware of the general position in relation to how contracts and subsequent indemnities were negotiated and how this differed from the usual, non-pandemic, process. In relation to indemnities, the Government took a broader approach to indemnification that usual, given the competition from other nation states that had been offering indemnities as part of their contractual agreements, or as was the case with the US PREP Act, providing immunity to vaccine developers through legislation. Although the vaccines were developed at pace, there was no compromise on safety. Indemnities were offered in the unexpected event of adverse reactions that could not have been foreseen through the robust checks and procedures, including independent review and approval from the MHRA, that ensured the vaccines satisfied all necessary requirements for safety, effectiveness and quality. Further, the Government only acquired a contingent liability at the point of deployment, so if a vaccine was not ultimately used, no contingent liability would arise. This is why parliamentary notification followed the decision to deploy, rather than the decision to purchase.

85. The VTF procured vaccines on behalf of the entire United Kingdom so any indemnities that arose remained outside of the Barnett Formula. This was consistent with other work on vaccines including the Vaccine Damage Payments Scheme, to which vaccines against COVID-19 was added via statutory instrument on 3 December 2020. Vaccines were also supplied to Overseas Territories and Crown Dependencies with indemnity provided.

86. As set out in the table above, of the seven vaccines in the VTF's portfolio in December 2020, one vaccine did not make it to the UK market. In September 2021, the decision was taken by the VTF to terminate the UK's contract with Valneva.

87. As far as I am aware, the implications of contract termination for Valneva were carefully considered. Proposals to work constructively with the company to minimise any negative impacts included the following:

    a) The VTF to engage with Valneva at an appropriate time to minimise impact on their share price;
    b) Initiate discussions with Valneva on alternative uses for the Livingston facility to manufacture vaccines in partnership with other suppliers, thus protecting both investment and some jobs;
    c) Initiate discussions with Valneva on repurposing equipment and consumable stock that could be of value to other UK based vaccine manufacturers;
    d) Work with Valneva on the public framing of the termination to include any positive language around how we will work together on alternative uses for the Livingston facility;
    e) An overall handling plan to be prepared jointly between the VTF and DHSC.

88. The Secretary of State for DHSC and I both agreed to the recommendations, including that a meeting be set up between him and the Scottish Secretary for Health and Social Care, Humza Yousaf, on 11 September 2021, to inform him in advance, and in confidence, of the Government's intention to terminate the Supply Agreement, and reasons for this. I understand that the meeting was used to reassure the Scottish Government of the constructive work planned with Valneva to minimise the impact to the Livingston facility and any relationship with the pharmaceutical and bioscience industry to work effectively with the UK.

89. As part of the decision-making process, the Ministerial Panel was assured that the contracted volume of other regulated vaccines was sufficient to cover all likely scenarios for the anticipated booster campaign. The only potential negative impact anticipated in terms of UK stock was that this would potentially result in fewer doses being available to donate.

We were also assured that constructive work would continue with Valneva to minimise the negative impact on its business.

SECTION THREE: ELIGIBILITY AND PRIORISITATION

The Joint Committee on Vaccination and Immunisation (JCVI)

90. For background on the JCVI and its subcommittee on COVID-19, established in September 2020 and chaired by Professor Wei Shen Lim, I refer the Inquiry to paragraphs 100 to 106 of DHSC Statement A.

The basis and scope of JCVI advice

91. For detailed background as to the basis and scope of the advice received from JCVI during the relevant period, including a timeline summarising and exhibiting the relevant advice given and how it was considered in decision-making, I refer the Inquiry to paragraphs 197 to 280 of DHSC Statement A.

Decision-making and accountability

92. Decisions about the scope of JCVI advice were largely made by the Secretary of State for DHSC, based on clinical advice from the DCMO Professor Sir Jonathan Van-Tam and, from my understanding, the advice was largely followed. On both the Phase 1 and Phase 2 of the roll out, all four health ministers from England, Wales, Scotland and Northern Ireland jointly considered the advice from JCVI and all agreed to follow its recommendations on prioritisation. This was set out a joint letter to the profession on 31 December 2020 in relation to phase 1 **(NZ1/58 - INQ000305156)** and, in relation to phase 2, in a joint statement on 13 April 2021 **(NZ1/59 - INQ000399462)**.

93. My role was largely in relation to the implementation of JCVI advice, and, as set out in the example with pregnant women below, how changes in advice might be communicated. As set out in the sections of DHSC Statement A referred to above, I was also consulted on the approach to Phase 2 prioritisation and several specific decisions, examples of which I provide below.

94. As noted in the extract above, while the JCVI recommendations for Phase 1 prioritisation were based primarily on clinical advice designed to prevent mortality, morbidity and to protect the health care system, prioritisation decision-making for Phase 2 was more complex. This was noted in a submission I received on 22 January 2021 **(NZ1/60 - INQ000401329)**. The reasons for this included: the impact of the vaccine on transmission; duration of immunity; level of uptake (particularly by disproportionately impacted groups); and efficacy against novel strains.

95. On 22 January 2021, the Secretary of State for DHSC and I agreed to the approach suggested for resolving decisions about Phase 2 prioritisation and seeking further advice from JCVI and MEAG, given the identified unknowns from Phase 1 **(NZ1/60-INQ000401329)**. On 28 January 2021, at a Small Ministerial Group (SMG) meeting with the Secretary of State for DHSC and the Chancellor, we agreed that the approach to Phase 2 should align with the overarching priority of further reducing mortality, morbidity and hospitalisations. We agreed to take advice from the JCVI on the best strategy to achieve this.

96. On 12 April 2021, the Secretary of State for DHSC and I agreed to the publication of the JCVI final advice on Phase 2 **(NZ1/33 - INQ000499504).**

97. On 15 April 2021, the Secretary of State for DHSC and I received a submission seeking approval for the updated recommendation from the JCVI to offer routine vaccination in pregnancy to be made public via an update to the Greenbook **(NZ1/34 - INQ000111012).** The submission summarised the JCVI advice in relation to pregnant women as follows:

> *"The JCVI have now updated their advice for pregnant women, recommending routine vaccination is offered in pregnancy. This updated advice for pregnant women will be released via a fuller Green Book clinical update with all the latest new advice, on 16 April. The immediate timing reflects the fact most women who are pregnant will be in the 18-49 age group, with individuals aged 45-49 now being able to book appointments for their vaccination through the NHS booking service.*

Although clinical trials on the use of COVID-19 vaccines during pregnancy are not advanced, the available data do not indicate any harm to pregnancy. JCVI has therefore advised that women who are pregnant should be offered a vaccination at the same time as non-pregnant women, based on their age and clinical group. The JCVI continue to recommend that clinicians discuss the risks and benefits of vaccination with pregnant women, who should be informed about the limited evidence of safety for the vaccine in pregnancy.

The JCVI advice is that Pfizer and Moderna are the preferred vaccines for pregnant women of any age, because both Pfizer and Moderna have been routinely used in pregnancy in the USA with no safety signals so far[1]. This recommendation applies to pregnant women of any age. However, any pregnant women who have already had a first dose of AstraZeneca, are advised to have their second dose as planned. This is particularly important for health and social care workers and unpaid carers, who are currently pregnant, who may have already had their first dose of the AstraZeneca vaccine." **(NZ1/34 - INQ000111012)**

98. On 16 April 2021, the Green Book was updated to reflect the above JCVI advice for pregnant women, following my approval of the submission **(NZ1/61 - INQ000479228).** Pregnant women were to be offered the vaccine at the same time as the rest of the population, based on their age and clinical risk. The communication for such advice was to be made with the help of the Royal College of Obstetricians and Gynaecologists to amplify the message and provide independent, reassuring voices. Obstetricians, GPs and midwives would help incentivise the women to take up the vaccine by highlighting the potential harms of contracting COVID-19 while pregnant while explaining the new advice.

Other advice

99. I am not aware of any offer from the Nuffield Council or other body to produce ethical advice prior to the pandemic. The Moral and Ethical Advisory Group (MEAG) MEAG were consulted throughout the decision-making process on vaccine prioritisation and rollout for the relevant period, both before my tenure and during. A timeline of their advice is set out at paragraph 111 of DHSC Statement A.

100. Among the recommendations in the submission for input into the developing advice for Ministers on Phase 2, was to seek advice from the MEAG on the ethical implications of prioritising certain groups (especially if vaccination becomes associated with any additional freedoms) and of adopting a national versus regional approach **(NZ1/60 - INQ000401329)**. Further advice within the submission set out how the Public Sector Equality Duty (PSED) had been considered as part of the ongoing advice on Phase 2 prioritisation.

101. I agreed to the recommendations and the interim JCVI advice, as published on 26 February 2021. MEAG supported the interim advice approach and agreed on an age-based approach to prioritisation.

Children

102. For detailed background as to the advice received from JCVI in relation to children during the relevant period, including how it was considered in decision-making, I refer the Inquiry to paragraphs 250 to 269 of DHSC Statement A.

103. The extract above sets out in detail how the JCVI advice changed over the period, often in response to emerging data on potential side effects or threats of increased transmissions from new variants. In my experience, and as confirmed in the extract above, JCVI advice was followed. However, in relation to the changing advice regarding the vaccination of children, and in order to ensure the basis for any change in advice was clear, clarification or further advice was sought by the CMO on occasion. This was the case with advice provided by the JCVI in a submission that the Secretary of State for DHSC and I received jointly on 8 July 2021, seeking our **approval (NZ1/62 - INQ000309448)**. We agreed to the advice on the understanding that: *'the CMO will write to Professor Wei Shen, Chair of the JCVI for COVID-19, to ask that as JCVI continue to review their advice on vaccination in children that they provide advice that is explicit that the choice is one between the safety of infection compared with vaccination and then set out which is safer'* **(NZ1/63 - INQ000401359)**. The position of Devolved Administrations is also set out at paragraph 20 of the submission, which confirms that officials and ministers are sighted on all JCVI discussions and advice. It also recommended that this particular advice be discussed at the next Health Ministers Forum on 8 July 2021 to ensure alignment. This follows an earlier submission in relation to the

same advice as sent on 5 July 2021 which noted potential misalignment with Scotland **(NZ1/64 - INQ000309444).**

SECTION FOUR: VACCINE DEPLOYMENT

UK preparedness

104. As set out at paragraph 200 of DHSC Statement A, the prospect of a possible vaccination programme was being considered as part of discussions over the development and procurement of a vaccine.

105. My understanding of the UK's preparedness to promptly vaccinate the whole population in early 2020 is limited by the fact that I was not involved in the project until my appointment in November. The team had worked at pace throughout 2020 to build the deployment infrastructure in parallel with their work on procurement so the state of preparedness was already advanced by the time I arrived. I do not believe I can offer any valuable insight into the state of preparations in early 2020, further to that which has already been provided by other witnesses to the Inquiry for this module who were in the relevant appointments in early 2020.

The UK COVID-19 Vaccine Deployment Programme

106. For a summary of the genesis of the COVID-19 Vaccine Deployment Programme prior to my appointment, including the lead up to the publication of the Vaccine Delivery Plan (the Delivery Plan) in January 2021, I refer the Inquiry to paragraphs 281 to 301 of DHSC Statement A.

107. As set out in the extract above, the Delivery Plan was formulated with help from each of the Devolved Administrations. I also provided input **(NZ1/65 - INQ000479175) (NZ1/66 - INQ000479174)**, along with others from across government, including the Secretary of State for DHSC; the DCMO, Professor Sir Jonathan Van-Tam; and colleagues from the VTF, NHSE/I, PHE, MHRA and OGDs **(NZ1/67 - INQ000479176).**

108. Limiting factors to the pace of delivery were considered at the time of formulation of the plan, in particular with supply and logistics, given the complex storage needs of the Pfizer/BioNTech vaccine, as set out at paragraphs 236 to 245 of DHSC Statement A.

109. These logistical considerations of both the Pfizer/BioNTech and the AstraZeneca supply were being anticipated before the publication of the Vaccines Delivery Plan and therefore fed into the plan itself.

110. On 7 December 2020, colleagues from the VTF attended a joint COVID-O/XO meeting in my place for which an assessment of how the cold chain would be managed over the winter, in light of an EU transition **(NZ1/68 - INQ000146714).** I received the associate paper identified key risks to the cold chain in general, with specific input by the VTF to identify those that would relate to the supply of COVID-19 vaccines and other pharmaceuticals. The VTF produced a paper on supply chain risks facing the programme for vaccines and antibodies **(NZ1/69 - INQ000479153)**.

111. The VTF paper identified key risks and mitigations to the supply chain in relation to the supplier agreements with both Pfizer/BioNTech and AstraZeneca for the supply of 40 million doses and 100 million doses respectively. By way of example, I summarise some of the key risks and mitigations identified for each vaccine as follows:

a) Pfizer/BioNTech

i. Risk: Temperature controlled transport and distribution: the vaccine must be maintained at an ultra-low temperature during transit and storage (-75oC (+/- 15oC)), once thawed the shelf life is 5 days at 2-8oC, once ambient the shelf life is 6 hours;

Mitigation: Pfizer/BioNTech set up their supply chain to manage delivery to the PHE distribution hub; dry runs were being conducted and additional support offered to Pfizer/BioNTech

ii. Risk: Alignment with deployment: if the delivery profile does not align with wider UK deployment capacity, potentially impacting shelf life and placing additional strain on cold chain capacity;

Mitigation: detailed planning with DHSC's Deployment teams to minimise misalignment;_VTF delivery model being set up to identify and manage variations; Pfizer/BioNTech contract terms include a controlled call-off in line with demand

iii. Risk: Security: as the first vaccine made available, there was a high risk of disruption from organised crime, anti-vax or hostile state actors;

Mitigation: Security services were involved in an advisory capacity to Pfizer/BioNTech with specific mitigations recommended to suppliers and distribution sites and links to local law enforcement capabilities made available;

iv. Risk: EU End of Transition Period: planned delivery profile coincided with the end of transition period creating risk of delays and loss due to need for tight temperature controls;

Mitigation: regular reviews with Pfizer/BioNTech to identify risks who confirmed they had robust contingency plans (including air freight) and the use of multiple ports and pre-registering their carrier to book tickets for the Government freight capacity;

b) Oxford/AstraZeneca

i. Risk: late delivery: planning assumptions used are best so suppler at risk of not achieving the target ramp up profile and have already communicated scale up issues;

Mitigation: close engagement with the supplier and regular communications with Deployment teams and wider stakeholders to align delivery expectations;

ii. Risk: security: assessment of product facility highlighted concerns;

Mitigation: support provided to improve security including additional guards and cyber protection;

iii. Risk: EU End of Transition Period: risk that disruption impacts delivery of initial batches which are being finalised within the EU;

Mitigation: Oxford/AZ secure access to Government Secured Freight Capacity system and planning to avoid Short Strait routes where possible, direct EU to NI supply chain being established to mitigate regulatory risks

112. In light of the anticipated limiting factors to the delivery plan, the strategy necessarily required a level of dynamic implementation, responding to lessons learned in real time and overcoming various hurdles as set out in further detail below. The lessons already being learned in early 2021 and how these could be used to improve strategy were, however, not limited to the VTF or its outputs. As the deployment programme was launched and scaled up, initial lessons were being incorporated into wider routine vaccine strategies.

113. Concurrent to the formulation of the Delivery Plan, an overall long-term 'All Vaccine Strategy' was also being prepared. In February 2021, I was consulted, along with the Secretary of State for DHSC and other representatives from DHSC, the VTF, BEIS on the publication of a strategy on routine vaccination programmes to reverse the decline in uptake rates, reduce inequalities, and improve services for under-vaccinated groups. A draft strategy, which formed part of a manifesto commitment, had been prepared in October 2019 but publication had been paused in March 2020, due to the outbreak of COVID-19. Since the draft strategy was paused, there were significant changes in the vaccine landscape with the COVID-19 vaccine roll out and the work of the VTF. There was therefore strong rationale for incorporating initial lessons from the start of the roll out, building on momentum to support the recovery of routine immunisation services.

114. I agreed to the Secretary of State for DHSC's proposal that the VTF should contribute to and include its own long-term strategy within the overall All Vaccine Strategy, feeding into existing strategies, rather than have its own standalone long-term strategy. I suggested that the VTF would still need short-term operational plans for vaccine variants separate to the All Vaccine Strategy but agreed that it was important to consider the future of COVID-19 as a routine programme whilst acknowledging that there would still be significant unknowns by the proposed publication date in June 2021 **(NZ1/70 - INQ000479208) (NZ1/71 - INQ000479207).**

My role

115. As set out above, prior to my appointment, Emily Lawson was appointed as the single SRO in NHSE for COVID-19 Vaccine Deployment. She was, in my opinion, very experienced and certainly capable of managing the rollout of the vaccine within the NHS. Where NHS and government operations met, however, a dedicated point person was

needed in Whitehall to facilitate conversation in both directions. I had 10 years of political experience and another 20 years in sales and operations and also knew how to navigate the corridors of political power. My role, and the skills I was able to draw on, meant that individuals like Ms Lawson could better focus on the task at hand, leaving me to liaise with senior advisors and politicians on their behalf.

116. One of the greatest challenges that Ms Lawson's team faced was the pressure to deliver without being distracted by the need to reassure Central Government and the public that deployment of the vaccine would be a success. As I have set out above, there was a perceived lack of confidence following the experience of Test and Trace and PPE. This meant that there was a need to maintain public confidence, especially since uptake would depend on it. Throughout my time in the post, I would speak to the PM almost every evening and responding to external questions on behalf of the VTF became a large part of my role.

117. With this in mind, from 11 December 2020, I set up a weekly Zoom call, inviting all 650 MPs to join, often with the attendance of Emily Lawson, clinical lead of the programme, Nikki Kanani, and Dr Jonathan Leach and Professor Anthony Harnden from the NHS. This enabled MPs to air concerns from their constituents and be offered reassurance about the decisions we had made, with evidence in support. It became an important way to transfer the confidence I had in Ms Lawson and her team to MPs and, by extension, the public.

118. There were two decisions that I consider key to the success of the deployment of the vaccine: the decision to prioritise according to age; and the decision to increase the interval between first and second doses. Both of these decisions were the subject of challenge by MPs at our weekly calls, which naturally reflected the concern of the public, and I consider the calls to have been an incredibly useful tool to understand the bases for these challenges to ensure we had considered all possible alternatives. The calls were also vital to our ability to robustly defend our decision and provide the reassurance that MPs needed to support our approach.

119. In both decisions, we followed JCVI advice. The advice to prioritise primarily by age was based upon evidence which firmly indicated that offering vaccination to older age groups first was the optimal strategy for both minimising future deaths and minimising quality

adjusted life year losses. This decision was challenged by some MPs and the public who called for teachers to be included in the earlier cohorts to mitigate further disruption to education and as a means of showing staff they were valued. I include readouts from MP calls where this issue was raised, on 23 December 2020 **(NZ1/72 - INQ000479165)** and on 4 January 2021 **(NZ1/73 - INQ000479168).** Following a petition, the issue was also debated the issue in Parliament on 11 January 2021 to which the Government published its response **(NZ1/74 - INQ000479177).**

120. Although valid arguments were raised, the decision to not deviate from the JCVI advice was, in my opinion, correct and proportionate, not least for logistical reasons. Operational feasibility was rightly one of the four main principles that NHSE implemented through the JCVI's prioritisation programme. Deciding the criteria for prioritisation from the many types of professions within the education sector would have been the first hurdle. Secondly, establishing this information effectively in each candidate would have created an additional administrative step in the process and resulted in inevitable delay to the rollout. Sending invitations by age is far more straightforward, and crucially is based on information that the NHS already holds. It has to be remembered that the NHS does not track the professions or work of patients. Had we given in to political pressure to prioritise teachers or any other key workers, save for the very early prioritisation of health and social care workers, I believe that there would have been extensive delays to the vaccination of cohorts with older, more vulnerable individuals.

121. The decision to prioritise first vaccine doses by extending the interval between doses from 3 to 4 weeks to up to 12 weeks, again followed JCVI advice given on 30 December 2020. This decision was also the subject of scrutiny at my weekly MP calls around this time **(NZ1/73 - INQ000479168) (NZ1/75 - INQ000479182).** Again, I believe the correct decision was taken and reasons communicated to MPs at the time. Releasing second dose vaccination slots in itself means more people are given at least one dose, but it also frees up stock. With shorter intervals, vaccine doses are held back to ensure there is enough stock to administer second doses of the same type of vaccine. Longer intervals make deployment more efficient; putting less pressure on the supply chain and reducing the need for stockpiling doses for second doses. In short, more doses can be deployed at any one time. As set out in the Technical report on the COVID-19 pandemic in the UK, (the Technical

Report) published on 1 December 2022, the decision was *'supported by surveillance and laboratory data proving higher effectiveness of the 12-week interval strategy compared with 3 to 4 weeks'* **(NZ1/76 - INQ000203933).**

122. As part of my role in communicating the VTF's progress with Central Government, I also attended weekly vaccine deployment meetings with the PM. I exhibit readouts from meetings I attended on the following dates:

a) 29 December 2020 **(NZ1/77 - INQ000234268)**
b) 7 January 2021 **(NZ1/78 - INQ000234278)**
c) 12 January 2021 **(NZ1/79 - INQ000063195)**
d) 14 January 2021 **(NZ1/80 - INQ000479179)**
e) 21 January 2021 **(NZ1/81 - INQ000145743)**
f) 10 February 2021 **(NZ1/82 - INQ000354664)**
g) 17 February 2021 **(NZ1/83 - INQ000479209)**
h) 24 February 2021 **(NZ1/84 - INQ000479211)**
i) 9 March 2021 **(NZ1/85 - INQ000479219)**
j) 27 April 2021 **(NZ1/86 - INQ000479231)**
k) 12 May 2021 **(NZ1/87 - INQ000479232)**
l) 2 June 2021 **(NZ1/88 - INQ000479235)**
m) 16 June 2021 **(NZ1/89 - INQ000479236)**
n) 22 June 2021 **(NZ1/90 - INQ000479238)**
o) 26 July 2021 **(NZ1/91 - INQ000479241)**

123. To illustrate further how my role functioned within the rollout of the COVID-19 vaccine deployment programme, I set out the following examples of key decisions in which I was actively involved:

Patient Group Directions (PGD)

a. PGDs provide the legal framework that allows registered health professionals to supply and/or administer specified medicines without having to be a prescriber (such as a doctor or nurse prescriber). Ordinarily, obtaining a PGD certificate would take 12 weeks. Within the first days of my appointment, I became aware that there could be a number of nurses ready to administer

the vaccine but still awaiting certification. With the assistance of the DCMO Professor Sir Jonathan Van-Tam, we were able to reduce the approval process to a matter of days and ensure that we were not solely reliant on prescribers in the first weeks of the rollout, which could have been a rate limiting factor (**NZ1/92 - INQ000479154**).

Agreements with pharmacy chains such as Boots and Superdrug

b. In December 2020, I engaged in negotiations with the CEO of Superdrug, Peter Macnab to seek their provision of mass Pfizer/BioNtech vaccination sites at 26 locations where their registered pharmacy sites had at least 2 consultation rooms as well as deployment of the Oxford/AstraZeneca vaccine more generally through the majority of their pharmacy and nurse clinic sites **(NZ1/93 - INQ000479164).** I provided an update on using commercial pharmacies at the daily vaccine meeting on 6 January 2021, noting that Boots had confirmed they were able to convert 100 outlets into vaccination centres at cost **(NZ1/94 - INQ000479170).**

Export of AstraZeneca vaccine from the EU and India

c. Between January and March 2021 relations became strained between the UK and the EU due to a perceived preferential treatment of the UK by AstraZeneca and there was a risk that a number of doses on order from HALIX in the Netherlands would not be released in time. There was some deal of political engagement at an international level required to overcome the challenges to exporting the vaccine to the UK. To ensure AstraZeneca were able to commit to our agreement to supply 10 million doses by the end of March, I engaged in negotiations with Pascal Soriot to help fast track inspections to approve manufacture at the Serum Institute India (SII), who were a licensee for the AstraZeneca Vaccine. The result of which was that our supply agreement would be conditional on the UK releasing 700,000 AstraZeneca doses from the UK supply chain **(NZ1/95 - INQ000479212) (NZ1/96 - INQ000479213) (NZ1/97 - INQ000479214)**. When I discussed this with the PM, he agreed with me that it was a necessary concession to guarantee the release of our sizeable order, and, following my approval, the

doses were released and we mitigated potential losses **(NZ1/98 - INQ000479191)**.

d. In March 2021, there was a delay to the delivery of the second batch of AstraZeneca from SII. A total vaccine export ban from India was anticipated which could have had an impact on our ability to deliver the doses offered to cohorts 1-9 by 15 April 2021, as per the public commitment **(NZ1/99 - INQ000479220).** One of the ways in which we successfully mitigated for this delay was to ensure that local deployment sites were notified of the delay and the rollout of first doses of AstraZeneca was paused, reserving existing stock to ensure that second dose appointments were honoured.

The management of supply and distribution

124. In the early months of the rollout, the overall global supply of vaccines was constrained and unpredictable, which naturally impacted the way in which distribution was managed within the UK. The delivery dates for the initial contracts were not binding but rather relied upon manufacturers doing their best to meet anticipated schedules. The VTF's approach was to work collaboratively with manufacturers to overcome hurdles and mitigate them through the supply chain up to and including local vaccine deployment sites, where possible. The VTF, PHE and NHSE&I met weekly to discuss supply and distribution issues and I know that a large degree of flexibility was needed to absorb disruptions by taking deliveries at short notice and dealing with cancellations or deliveries of short-dated stock. While I believe transparency and information sharing with vaccination providers and the public was key, it was thanks to the dedication and goodwill of all those involved that we were able to successfully manage the disruptions.

Protection of the supply chain

125. In December 2020, following the appointment of Richard Alcock as SRO for Vaccine Security, the UK COVID-19 Vaccine Security Team (UKCVS) was set up to support the SRO in his task to ensure and assure the end-to-end security of vaccine deployment across the

UK. For more detail on the work of the UKCVS, I refer the Inquiry to paragraphs 324 to 328 of DHSC Statement A.

126. On 14 January 2021, I was sent a submission that identified an *'increased and very real risk that an outbreak of COVID-19 at critical notes in the UK's immediate COVID vaccine supply chain will delay supply of vaccines'*. The proposed solution was to agree to the '*vaccination of up to 2,000 vaccine supply chain workers who were Good Manufacturing Practice (GMP) qualified and essential to delivering immediate COVID-19 supply'* **(NZ1/100 - INQ000110365)**. I agreed to the proposal which would lead to an amendment of the definition of 'frontline healthcare workers' in the Green Book to include such GMP qualified workers. I also spoke to my ministerial counterparts in Scotland and Wales to ensure individuals in their nations (around 580 of the 2000) were also offered the vaccination.

Protection against waste

127. The overall stock loss for England was significantly lower than the programme's original planning assumption of. I believe this successful mitigation of waste in such challenging conditions is a result of the detailed planning for risks to the supply chain as anticipated by the VTF in their December 2020 paper **(NZ1/69 - INQ000479153)** and the dynamic management of the supply chain. For example, when changes in eligibility criteria for AstraZeneca led to some excess stocks in vaccination sites, some were identified as being either past, or very close to, their expiry date. The total number of doses identified by the Vaccine Deployment Programme for recovery and disposal was 1.6 million, which represented less than 5% of the total stock issued to sites and significantly lower than the original planning assumption of 20%. I received a submission on 16 August 2021 which set out the specific mitigating actions that had been taken to keep this figure so low, which I summarise as follows **(NZ1/101 - INQ000499508) (NZ1/102 - INQ000499509)**:

a) 4 million doses that had been allocated to England were given back to the VTF/PHE to offer outside the country on 5 July 2021;
b) MHRA worked flexibly with colleagues in NHSE to enable a 'mutual aid' policy so stocks could be moved between GPs;

c) Outbound volumes of AstraZeneca were restricted from the first week in June 2021, which NHSE only sending out what was needed for second doses and challenging NHS regions to mutually aid stock where possible, rather than pull more.

128. I set out the below further examples to illustrate this dynamic approach to management of the supply chain to mitigate waste.

129. As identified in the VTF paper, due to the ultra-low temperature-controlled transport and distribution required for the Pfizer/BioNtech vaccine specifically, any misalignment between supply and delivery could have created a significant risk of waste. One of the mitigations applied was detailed planning and a VTF delivery model to identify and manage variations. An example of such mitigation in action was the decision taken in April 2021 to withhold Moderna doses to create a stockpile. This was discussed at a daily vaccines meeting that I attended on 13 April 2021 **(NZ1/103 - INQ000479227)**. Ms Lawson explained the rationale behind withholding Moderna doses, to create a stockpile if needed for under 30s, using up Pfizer/BioNTech supply instead. This created a more robust supply chain protecting against any geopolitical uncertainty and risks.

130. Another example of the innovative approach taken to the supply chain to ensure efficiency was with the assistance of the private sector, namely DHL, who produced what we called 'pizza boxes', which were state-of-the art GPS temperature-tracked boxes designed to deliver batches of vaccines to GPs and other parts of the infrastructure. As described on their website, DHL:

> *'...quickly brought new, dedicated services online to safely ship high volumes of highly temperature-sensitive vaccines, along with additional materials, like syringes, bandages, and saline solution. In addition, we introduced state-of-the-art GPS temperature trackers into the vaccine supply chain to monitor conditions in each shipment. We also pack everything with dry ice in special active thermal containers to ensure these incredibly fragile vaccines arrive safely.'* **(NZ1/104 - INQ000479252)**

131. Although the deployment of the vaccine was a devolved issue, the MOU that I approved in November 2020 to address the geographical hurdle to delivery of the Pfizer/BioNTech vaccine to Wales is another example of the way in which the programme required a creative and collaborative approach to manage the supply chain and reduce the risk of waste.

Ensuring the distribution was fair

132. The overall approach to ensure equitable access to the vaccine is summarised at paragraphs 5.4 to 5.7 of the Delivery Plan which I set out as follows:

> ***"Safe, convenient and equitable access***
> *The number of vaccination sites across the country will match expected vaccine supply. The capacity and mix of sites must also ensure safe, convenient and equitable access to vaccination in the order of JCVI cohort prioritisation. This requires the right clinical protocols, invitation and booking systems and clear public communication.*
>
> *Vaccinations will be offered at:*
>
> *Larger vaccination centres*
> *A new approach in the NHS, these are large-scale venues, with higher throughput, using re-purposed venues, including sports stadiums, theatres, and hotels, located within communities to vaccinate large numbers of people. People will be offered an invitation and can book a slot that suits them using the National Booking Service.*
>
> *Hospital hubs*
> *These are based at NHS trusts, including acute, community mental health and ambulance trusts. They are targeting our health and care workers and will work closely with local authorities, local resilience forums and providers to coordinate rapid vaccination of the workforce. They are also excellent locations for initial deployment of new vaccines, so that all clinical safety issues can be identified and managed before wider roll-out. This has been the approach taken with the launch of the Pfizer/BioNTech and the Oxford/AstraZeneca vaccines.*

Local vaccination services

These mobilise general practice, working together in groups of primary care networks plus large and small community pharmacy sites. These services provide the largest number of locations and are well placed to support our highest risk individuals, many of whom already have a trusted relationship with their local health services. They also coordinate and deliver vaccination to people who are unable to attend a vaccination site, including visiting care homes, the homes of housebound individuals and other settings such as residential facilities for people with learning disabilities or autism and prisons and to reach vulnerable groups such as those who are experiencing homelessness.

The plans for the right mix of vaccination sites have been developed jointly between national, regional and local teams to ensure the mix is right for the population and communities it serves. The needs of rural and urban communities will be very different, and the needs of individual groups and communities need to be reflected in the local mix of sites.

The mixed model will ensure that different communities access the vaccine in a way that is clinically and operationally secure. For example, it is not generally clinically appropriate for care home residents to go to hospital hubs. But others not resident in a care home are more able to receive the vaccination in a local vaccination service run by the general practice team that knows them best. Community pharmacy sites will start to deliver vaccines from mid-January, offering bookings through the National Booking Service. This will help improve access through primary care to as many of the population as possible. The early community pharmacy sites will be able to offer significant numbers of appointments. Community pharmacies are integral parts of local communities and will be accessible and approachable places from which to deliver vaccination." **(NZ1/7 - INQ000399454)**

133. As referred to above in the subsection on Local Government in Section One, collaboration with Local Authorities was central to managing any disparities in distribution. I refer the Inquiry to paragraphs 310 to 323 of DHSC Module 4 C, which sets out the steps taken to ensure fair distribution, taking into account various barriers to access.

Impact of prioritisation and eligibility

134. As already cited above, DHSC Statement A sets out the timeline of JCVI advice which was, on the whole, followed when making decisions on prioritisation and eligibility. The extract shows how these decisions would impact the deployment programme and how, in turn, supply considerations would inform decisions about dosage intervals, for example, as set out at paragraphs 276 to 279.

135. Mitigating the impact on the deployment programme from these changes that had to be implemented at short notice was an ongoing consideration. For example, at a daily vaccines meeting that I attended on 11 June 2021, the anticipated formal advice from the JCVI on the vaccination of children was discussed and how deployment options would need to be considered following the decision, with agreement needed from devolved administrations **(NZ1/105 - INQ000479237)**. The bringing forward of second doses for over 40s was also considered in relation to the effect this may have on the limited supply of the Pfizer/BioNTech vaccine.

Devolved administrations

136. The role of Devolved Administrations in relation to the prioritisation and deployment of vaccines is summarised at 302 to 306 of DHSC Statement A.

137. Although deployment is a devolved issue, as an example of the involvement I had with the vaccine delivery across the nations of the UK, I refer again to the MOU with Wales I approved in November 2020 to adapt the delivery plan for the Pfizer/BioNTech vaccine to account for the geographical variations **(NZ1/15 - INQ000479012) (NZ1/16 - INQ000479010) (NZ1/16a - INQ000479146)**.

138. As noted in the extract above, given the local approaches taken to delivery, it is difficult to comment on the specific adaptations on the grounds of geographical and demographic variation. Generally, the pace of delivery in all four nations was aligned but where it occasionally diverged, efforts were made to provide assistance from Central Government where needed. For example, in February 2021, the UK Government worked with the Health

Ministers for Wales and Scotland to provide an increase in service personnel to support their health boards in rapidly establishing and operating vaccination centres. This was a reflection of the enormity of the task to ensure alignment in the rate of distribution of the vaccine between the four nations and showed the strength of collaboration involved, which I noted in the joint press releases at the time **(NZ1/106 - INQ000479197) (NZ1/107 - INQ000479201) (NZ1/17a - INQ000234621).**

Data collection

139. How local data collection on vaccine coverage fed into national level decision makers is summarised at paragraphs 307 to 308 of DHSC Statement A.

140. Local data from England and from each of the devolved nations was provided to JCVI advice separately which, through their advice, would feed into national level decision-making. The need, therefore, to align data cycles with the devolved nations was considered at an early stage. The Minister of Health and Social Services for Wales, Vaughan Gething, and I agreed to this approach at a meeting on 16 December 2020 **(NZ1/11 - INQ000479159).**

141. In my experience, the data collection undertaken was both sufficient and appropriate for the purposes of decision-making. At first, the NHS were only publishing weekly data, but my instinct from my time in YouGov was to be more frequent and more granular with the data.

142. Daily publication of data at any other time would have required substantial resources but with the Foundry platform, we already had the information in a manageable format on a daily basis, it was just a case of sharing it. The US software Palantir developed the platform that showed daily figures on both the timing and location of vaccinations as well as the demographic of those vaccinated **(NZ1/108 - INQ000479251)**. This was critical for both my understanding of how the deployment programme was progressing and my ability to share clear data with the executive and the public with complete transparency. The data was particularly critical to decision-making and a huge part of the programme's success.

143. Collecting data on refusal rates would have, on the other hand, demanded a disproportionate level of resources. I accept that data on vaccine no-shows or declines may have helped with local understanding of vaccine uptake and hesitancy, which was discussed

at my meeting with local leaders and city mayors on 2 February 2021 **(NZ1/109 - INQ000479199)**. From my understanding however, compiling accurate data on the reasons for no-shows or refusals would have been incredibly resource heavy. We were working with data that, on the whole, was readily available, such as the age, ethnicity and location of individuals taking up the vaccine. Collecting data on refusals would have, to some extent, involved locating and surveying such individuals as to whether it was a wilful refusal or an error in date/time. Even with unlimited time and resources, I do not believe the data would have added substantial insight to that already being gained through the detailed breakdown of uptake data and our engagement at local level with individual groups, for example.

144. I also note that our policy of always being open for people to come back and request a new date for a vaccination would mean that if we did try and track refusals we would also have to constantly update the list of who has rebooked and been vaccinated. For more on these issues see references to the Evergreen strategy below.

Consideration of vulnerable or marginalised groups

145. The consideration given to marginalised and vulnerable groups, including: the prison population; the homeless; Black, Asian and minority ethnic groups and those with other protected characteristics; the Clinically Extremely Vulnerable (CEV); those with language or other barriers to communication including learning and other disabilities; and those with unconfirmed immigration status, with reference to JCVI advice and the Vaccine Uptake Plan is summarised at 246 to 249, 206 to 215 and 310 to 323 of DHSC Statement A.

146. To the best of my understanding, I had no direct input in the decision to include disabled people in priority groups for vaccination. I did receive a letter on 15 December 2020 from the minister for disabled people seeking clarity on the definitions within the JCVI cohorts on various categories of disabled people and offering support on issues of accessibility **(NZ1/110 - INQ000499492) (NZ1/111 - INQ000499493).** I responded on 24 December 2020, setting out the measures in place to address accessibility and reassuring him of how JCVI advice was being followed **(NZ1/112 - INQ000499495) (NZ1/113 - INQ000499496).** The decision to include disabled people in priority groups followed the final JCVI advice on Phase 1 on the basis that the advice was comprehensive, and I had every confidence that

sufficient preparatory work had been undertaken, looking into every possible approach, to ensure that it could be relied upon to make informed decisions on prioritisation. I was aware that sometimes communications on the vaccination delivery and progress could be prone to variation, given that, at a local level, it often relied on Local Authorities and local clinicians to coordinate. On 10 January 2021, following the JCVI final advice on Phase 1 prioritisation, I was copied into an email from the Secretary of State for DHSC acknowledging such variations and highlighting the importance of coordination between NHS and Local Authorities in reaching groups such as the disabled **(NZ1/114 - INQ000499498)**. Ahead of a COVID-O meeting that I attended on 22 January 2021 on driving uptake, a paper was shared setting out the overall approach and objective as well as more detail on specific barriers to uptake and the work that was underway to reduce these, which I subsequently approved **(NZ1/115 - INQ000499500) (NZ1/116 - INQ000499499).** Specific reference was made to the Disability Unit who had been engaging with disabled people through their nine English Regional Stakeholder Networks. They identified a need for accessible communications which would include information about where to go for the vaccine. Guidance was then published by PHE in British Sign Language, braille, and large print. I would always be interested to know from any community about our attempts to communicate but I am confident that there were no substantial issues; every attempt was made to effectively communicate the decision as clearly as possible.

Transparency

147. I believe transparency with the public worked particularly well through the means of communication as already mentioned, such as the daily publication of vaccine data and press briefings, weekly MP Zoom calls and the publication of the Delivery Plan and advice from JCVI and UK CMOs. I believe that the programme's early clarity of purpose and prioritisation, with explicit objectives, was of particular value. I also believe that the programme was open about vaccine supply uncertainties and were therefore able to act promptly to update guidance and ask local providers to plan around this.

148. Deployment was determined by the availability of supply and this was communicated to the public throughout; public commitments were based on our best estimates of future supply so where this fluctuated, or when different stages of the rollout needed to be

accelerated in response to changing conditions such as the Delta variant, changes were communicated as quickly as possible. Reasons for such fluctuations, where possible, were shared with the public and MPs through statements by the Secretary of State for DHSC in the House of Commons, for example. This was the case on 18 March 2021 when the anticipated delay to the delivery of the second batch of AstraZeneca from SII was communicated to the House as well as the effect this would have on deployment.

Support at a local level

149. As set out at paragraph 309 of DHSC Statement A, detail of local level roll out is a matter for NHSE. Clinical Commissioning Groups (CCGs), which were the statutory bodies for the majority of the time period covered by this statement, played a central role in delivering roll-out, including monitoring capacity across the local system and ensuring vaccination sites were able to deliver vaccines to their local population.

150. As I have set out above at paragraph 35, a collaborative approach was taken between Central Government and Local Authorities in relation to the rollout. By discussing details of the delivery plan early on, a two-way communication between ministers and local leaders was being established to ensure targeted support could be easily sought and provided through local channels.

151. In my experience, local vaccination centres were well supported. Planning for sufficient support to local vaccination centres was central to the programme. This was also shown in the steps taken to secure such a large workforce of professionals and volunteers to support the work at the ground level, as with the fast-tracking of the PGD approval process set out above, allowing more certified vaccinators to be deployed in the early days of the roll-out.

Dealing with concerns

152. As referred to above, the weekly MP Zoom calls provided MPs an opportunity to air concerns from individuals and groups within their constituencies as well as help us to address any inconsistencies and ensure fair distribution. On these calls I often received specific questions about localised problems with supply and where I was unable to provide an immediate answer from the available data, or with an updated delivery date, for example,

I would take the message back to my team to provide a targeted response **(NZ1/117-INQ000479188).**

153. As set out in the Vaccines Delivery plan, drawing on local leaders' knowledge of their communities was key to addressing disparities in access or fair distribution of the vaccine. To the best of my knowledge, representations from individuals and organisations with such local knowledge were actively sought and deemed vital to decision-making around uptake and disparities, as set out at paragraph 60 of DHSC Statement C.

A story of success

154. The Government made a number of public commitments on how quickly groups would be offered the vaccine. Many of these targets were based on and supported by the Vaccines Delivery Plan which, as set out above, was the result of months of preparation by the VTF, the NHS, PHE, research institutions, the Armed Forces and regional and Local Government. At the time of publication of the Delivery Plan, the timetable was noted as 'ambitious' but meeting the target of offering a vaccine to everyone in the JCVI cohorts 1-4 by 15 February 2021 was stated as a 'top priority'.

155. As with all major decisions about the rollout and prioritisation, the targets set through the Delivery Plan were in line with JCVI advice. According to its code of practice, the JCVI itself is made up of representatives from academia as well as practicing clinicians with expertise in a number of areas **(NZ1/118 - INQ000145984)**. Further, the committee will include at least one lay member to provide a wider lay perspective on issues. Individuals and representatives from other organisations may also be invited to JCVI meetings to provide input. The basis of their advice, therefore, reflects a broad spectrum of clinical professional experience which as set out in detail above, in turn, fed into policy and strategy for the COVID-19 vaccine deployment programme.

156. Tracking progress of the rollout against these targets was made public through the weekly UK-wide data on the total number of vaccinations **(NZ1/119 - INQ000479250)** as well as more detailed breakdowns by region through NHSE&I.

157. Up to July 2021, all major deployment targets were met, including offering vaccines in all care homes by 31 January, to the first four priority groups by 15 February, and to the first nine priority groups by 15 April 2021, and vaccinating two-thirds of all adults by 19 July.

158. In my experience, the vaccine deployment programme was a clear success as evidenced in the meeting of its ambitious and unprecedented targets, in a short space of time, in the middle of a global pandemic.

SECTION FIVE: VACCINE UPTAKE AND PUBLIC MESSAGING

Disparities in coverage, barriers to uptake and vaccine hesitancy

159. For a summary of the approach taken by DHSC, NHSE/I, PHE/UKHSA and the VTF to identify disparities and how uptake data fed into decision-making and was published, I direct the Inquiry to paragraphs 59 to 77 of DHSC Module 4 Statement C.

Steps taken to address vaccine uptake

160. As with the UK's state of preparedness to promptly vaccinate the whole population in early 2020, my understanding of the nature and extent of preparation and planning on vaccine uptake and hesitancy prior to my appointment is limited. I am aware that existing experience of past vaccination programmes indicated that uptake was likely to be lower amongst ethnic minorities. Vaccine hesitancy across BAME communities was discussed from my very first meetings with the team when I noted how impressed I was with the plans already put in place in such key areas such as this **(NZ1/120 - INQ000479158)**.

161. Funding was provided as early as July 2020 to support inclusion of ethnic minority participants in COVID-19 research which led to the INCLUDE Ethnicity Framework for clinical trials. The lower ethnic minority participation in vaccine trials was the reason for my own participation in the Novavax vaccine trial, prior to my appointment as Minister for COVID-19 Vaccine Deployment. On 11 November 2020, I posted an update on my public X (formerly Twitter) profile with a photo of me receiving the vaccine and celebrating the efforts of the volunteers and staff **(NZ1/121 - INQ000479145).** It was important for MPs from ethnic minority backgrounds, such as Treasury Minister Kemi Badenoch and me, to be seen to be

taking part in such trials to boost confidence and urge more people from ethnic minority backgrounds to sign up to vaccine trials **(NZ1/122 - INQ000479195)**. I was also one of a number of black MPs from across the Conservative and Labour party that produced a joint video to encourage vaccine uptake in the black community **(NZ1/123 - INQ000479192).**

Regional engagement

162. Vaccine confidence was an integral part of why many communities had lower uptake than others. Further to the extensive work of DHSC and OGDs in identifying the extent and reasons for such mistrust at a local and regional level, I engaged with MPs, mayors and local leaders as part of the development of a vaccine uptake strategy as set out below.

163. As set out above at paragraph 31, on 8 January 2021, I asked ministers from DHSC and MHCLG to attend a round table to discuss how we could work across Government to ensure communities with lower uptake are reached **(NZ1/124 - INQ000479173)**.

164. On 21 January 2021 I attended a meeting with Lord Hastings and Kenny Imafidon from Clearview research, who conduct participatory and community-based research. We discussed concerns around vaccine uptake among black communities and I agreed to share details of the vaccine uptake strategy with Mr Imafidon who, in turn, agreed to share insights from their work with Impact Health in Lambeth and Southward who were working on vaccine hesitancy in local communities **(NZ1/125 - INQ000479183)**.

165. It was through this engagement at a local and community level that much of uptake hesitancy was understood and addressed. For example, in early 2021, there were early reports of a perceived mistrust of medical professionals within the Jewish community, many of whom turned to their own Hatzola Ambulance service and medical professionals for advice. In order to address vaccine hesitancy within the community, arrangements were made for Hatzola to deploy the vaccine themselves within the community. Appointments could be booked through Hatzola, who shared the booking system with the local GP service and, using its fleet of ambulances to deploy the vaccine, provided transport to appointments and even arranged home visits for the housebound. On 13 February 2021, I posted on X.com (formerly Twitter.com) my thanks to the local NHS, Hackey Council and Hatzola Ambulance service who worked together to deploy the vaccine at an event at the John Scott

Health Centre in Hackney **(NZ1/126 - INQ000479206**). This was one of three vaccination events facilitated by Hatzola. By July 2021, over 1,000 vaccinations had been facilitated by Hatzola **(NZ1/127 - INQ000479234)**. These events were not exclusive to the Jewish community and a mixture of people from different background heritages would attend.

166. Other such clinics were also held in faith centres and places of worship in order to capitalise on the trust placed in religious and community leaders, such as the pop-up vaccination sessions held at the Finsbury Park Mosque, which was visited at the time by the then Prince of Wales **(NZ1/128 - INQ000479224)**. This engagement was seen not just as a way to deploy the vaccine to more people, but to build bridges with more isolated communities and build trust in the medical community more generally.

The COVID-19 Vaccine Uptake Plan

167. Uptake and disparities were at the forefront of discussions, and I agreed to the development of an uptake strategy from an early stage, noting the importance of capitalising on the window of public support available to us at the beginning.

168. On 27 January 2021, I sent an email to colleagues in the VTF asking for input into a public facing strategy document based on the COVID-O paper on driving uptake that could be shared with stakeholders. The early publication of such a document would enable us to address any criticisms prior to the target dates for vaccinating the top four cohorts, particularly if further data identified issues with uptake among certain communities. I proposed a meeting in the following days to discuss developing a 'Vaccine Uptake Strategy' **(NZ1/129 - INQ000479190)**.

169. At the meeting on 28 January 2021, I gave my comments on the strategy, which I thought was very good, noting the importance of acknowledging the scale of the challenge but demonstrating that we had a plan. I proposed building on the non-partisan approach that government, parliamentarians and civil society were taking to vaccine uptake and agreed to a timeline for the proposed vaccine uptake strategy, noting that this work was a priority for both the PM and the Secretary of State for DHSC. We also discussed the progress that the NHSE Equalities team had been making with engagement with faith leaders through their

Connect and Exchange Hub and ensured this would be incorporated into the strategy document **(NZ11/130 - INQ000479200)**. On 3 February 2021, I provided comments on a further draft which included the importance of showing which steps were being taken to address barriers to rough sleepers, undocumented migrants, those with unsettled status and the traveller community **(NZ11/131 - INQ000479198).**

170. The above strategy was put together into our COVID-19 Vaccine Uptake Plan which, prior to publication, I shared with BAME MPs during discussions on progress of the rollout and addressing disparities in uptake **(NZ1/132 - INQ000479205)**. On 13 February 2021, the Vaccine Uptake Plan was published, for which I produced a ministerial foreword jointly with the Secretary of State for DHSC **(NZ1/29 - INQ000234748)**. Further details of the purpose and scope of the plan with reference to specific groups are set out above at paragraph 145.

Collaboration with OGDs and the Government's equalities and levelling up agenda

171. In January 2021, I was commissioned by the Chancellor of the Duchy of Lancaster (CDL) to present a paper on driving vaccine uptake among vulnerable and harder-to-reach groups at a COVID-O meeting **(NZ1/133- INQ000479186) (NZ1/134 - INQ000479187)**. I worked with individuals from within DHSC, MHCLG, DCMS, CO, NHSE and PHE to ensure such aspects of the vaccine uptake had been considered across government. I also invited input and data and from specific groups such as the Equality Hub; Disabilities Unit; and the CO Race Disparity Unit (**NZ1/135 - INQ000479180)**. Collaboration with MHCLG on this paper (which later became the Department for Levelling Up, Housing and Communities DLUHC) is one example of how the Government's levelling-up agenda was considered. I exhibit further explicit references to levelling up at the following Ministerial meetings on 16 March 2021 and 20 May 2021 respectively **(NZ1/136 - INQ000479222) (NZ1/137- INQ000479233).** Although references to equalities and specific vulnerable groups are more frequently recorded in the material, my experience is that the Government's equalities and levelling up agenda was also at the forefront of plans to drive vaccine uptake across vulnerable and harder-to-reach groups, particularly at the local and regional level.

The Evergreen strategy

172. In order to encourage individuals to receive the vaccine, even if they had missed the timing of their first dose, I championed the 'Evergreen' strategy. This would enable individuals to come forward for their vaccine with a later cohort if they had missed earlier public calls on their cohort to receive their first or second dose. This was agreed through discussions with DHSC ministers and NHSE led the implementation of the strategy by making sure everyone continued to be able to book a first vaccine, even if the broader public campaign for their cohort had moved on. This was communicated to the public in the early days of the rollout, as noted in a Primary Care vaccinations meeting I attended on 25 February 2021 **(NZ1/138 - INQ000479215).**

The Vaccine Uptake Taskforce

173. In August 2021, I set up a Vaccine Uptake Taskforce (VUT). From 4 August 2021, I chaired weekly meetings bringing together colleagues from across NHSE, PHE and DHSC to ensure effective information sharing and planning for short and long-term uptake initiatives. The VUT brought together and coordinated local and national efforts to drive vaccine uptake. Membership included representatives from NHSE, JCVI, CO, UKSHA, Association of Directors of Public Health and DHSC. The meetings ran from August 2021 to December 2021.

174. At the first meeting on 4 August 2021, the terms of reference were summarised as follows **(NZ1/139 - INQ000479244)**:

a. The VUT is an opportunity to join up operational delivery across national leaders and government to implement policy. This should be action orientated for the taskforce to implement.
b. The VUT is a forum to bring together evidence-based delivery of policy and drawing on regional and local intelligence.
c. The VUT is to align work across government and avoid duplication.
d. The VUT is to engage all leaders to drive uptake.
e. The VUT is a forum to solve problems together; to draw on work to date and design new ways to solve problems.

175. At the meeting, we also discussed mapping community assets to explore correlation between availability of vaccination sites and uptake. Within the mapping, the composition of Community Champions was also to be considered to ensure greater diversity, especially for Black African and Black Caribbean communities. As set out above in the extract at paragraph 30, the Community Champions Programme worked with up to 65 Local Authorities to boost outreach to ethnic minority and disabled communities, including engagement around vaccinations.

176. Uptake data representation and how to use the statistics to support targeted messaging was also proposed such as, the positive correlation with being employed and addressing, therefore, the negative impact of being a student. Work was carried out with Local Authorities to provide positive vaccine messaging for younger cohorts showing how many of their peers in their area had been vaccinated.

177. Membership was also under constant review to ensure the widest impact. Following the meeting on 4 August 2021, the VUT invited further participants such as Directors of Public Health from high deprivation areas and surge areas that needed particular attention **(NZ1/140 - INQ000479243**).

178. At the VUT meeting on 11 August 2021 **(NZ1/141 - INQ000479245**), we focussed on Black and Caribbean uptake and discussed the proposals for various incentives to drive uptake. At the VUT meeting which I co-chaired with Keith Willett on 19 August 2021 **(NZ1/142 - INQ000479246)**, we focussed on the forthcoming Phase 3 of the rollout and the importance of targeted interventions to ensure groups are not left behind. It was noted that having a design for equity at the forefront of planning for the next stage of the rollout improves the chances of reaching everyone. Mr Willett shared a presentation on tackling vaccine hesitancy in Black African and Caribbean Londoners and how key lessons could be extrapolated and scaled up. We also received an update on the progress of the Community Champions programme, noting that over 14,000 community champions had been recruited by 31 July 2021. Although it was not possible to provide a direct causal link between the presence of Community Champions and vaccine uptake, there had been visible impact in coordinated events that reported additional vaccinations taken up by their activity.

179. At the VUT meeting on 26 August 2021 **(NZ1/143 - INQ000479247),** our focus was the importance of driving forward vaccine uptake of 16-17-year-olds ahead of the return to school. An update on progress with the 16+ social media campaign was provided and including how case studies had been incorporated into the messaging to improve effectiveness. In anticipation of eligibility opening up to 12-15-year-olds, agencies were also being commissioned to support a new campaign.

180. On 1 September 2021, I agreed with that advice on the future of the VUT that meetings be less frequent and chaired alternately with NHSE **(NZ1/144 - INQ000340275)**.

181. In my experience, inequalities were sufficiently and appropriately considered in relation to vaccine uptake. For a summary of the comprehensive way in which equality and inclusiveness analysis of vaccine deployment was undertaken and how this was used to increase uptake across different groups including: ethnic minority groups, pregnant, and breastfeeding women, I refer the Inquiry to **paragraphs 115 to 161** of DHSC Module 4 statement C.

Public messaging

182. For a detailed summary of how DHSC, in partnership with BEIS, MHRA, PHE, and DCMS, led on public messaging on vaccine safety, deployment and uptake and how its strategies underpinned key successes in deployment, I refer to paragraph 12 to 54 of DHSC Statement C.

My role

183. In relation to my role in public messaging, I would receive copies of daily social media evaluations. As an example, I exhibit: a daily media note I received on 6 January 2021 **(NZ1/145 - INQ000479171);** and a daily DHSC communications update I received on 5 February 2021 **(NZ1/146 - INQ000479202)**. I would also receive ad-hoc updates of media, social media and stakeholder engagement, following the publication of interim JCVI advice, for example, which I received on 5 July 2021 **(NZ1/147 - INQ000479240).** The content of these updates would feed into plans and discussions at meetings referred to below.

184. At a ministerial level, I was involved in regular comms discussions at the daily vaccines meetings. For example, at a daily vaccines meeting on 25 February 2021, I confirmed that the vaccines team are working with MHCLG on operational guidance to strengthen messaging on vaccinations for rough sleepers **(NZ1/148 - INQ000479216)**.

185. Public messaging was discussed at every Vaccine Uptake Taskforce meeting, where we received a dedicated COVID-19 comms update from attendees. For example, at the meeting on 4 August 2021, we discussed: the data driven communications approach; refreshing the campaign in relation to young people in particular which centred around a 'fear of missing out' on travelling and events; geo-targeting communications to make the cost more effective; and consideration of incentive work at local level. On 26 August 2021, we received an update on the comms campaign target at younger cohorts which was making use of social media, influencers and parents.

186. I chaired weekly comms meetings with DHSC press officers on all aspects of public messaging from how to increase vaccine confidence and uptake to publication of delivery and deployment figures. As an example, at the meeting on 3 March 2021, we discussed: media interest in subjects such as vaccine passports; engaging younger cohorts with family-centred vaccine messaging; urging local leaders to promote vaccination successes in their areas; a move of vaccine supply comms from the VTF to DHSC; and core principles on strengthening the Union messaging as part of the vaccine roll out **(NZ1/149 - INQ000479217).**

187. In relation to paid campaign activity this was delivered and paid for by the CO COVID-19 hub marketing team. My role, as stated in the extract above, was to provide ministerial approval. I and other departmental ministers were responsible for approval of all major CO COVID-19 hub public health campaigns.

188. I also provided ministerial approval for the publication of advice and recommendations, such as the change in public communications around offering an alternative to the AstraZeneca vaccine to young people **(NZ1/150 - INQ000411693).**

Effectiveness of public messaging

189. Although drawing direct causal links between public campaigns on vaccine hesitancy, for example, and an increase in uptake, is not straightforward, in my experience, the UK Government public messaging campaigns were, on the whole, extremely effective. The campaigns identified and targeted groups that were more vulnerable or more likely to be vaccine hesitant. The daily discussions around public messaging campaigns allowed us to quickly reevaluate and adapt the campaigns to deal with evolving advice, as with the examples of the change in guidance on pregnant women and offering young people an alternative to AstraZeneca.

Mis/disinformation

190. For a detailed summary of how DHSC, in partnership with OGDs and under the coordination of the CO COVID-19 hub, tackled misinformation and disinformation, I refer the Inquiry to paragraphs 196 to 212 of DHSC Statement C.

191. In relation to my role, I met regularly with the NHSE Director of Communications, Simon Enright, to discuss public messaging in general which, on occasion, covered issues around misinformation. For example, at a comms meeting on 18 December 2020, I shared a specific video that had been circulating on Whatsapp with Mr Enright to assist with countering misinformation on social media **(NZ1/151 - INQ000479166) (NZ1/152 - INQ000479167).**

192. I agreed with the Government's approach, as set out in the extract above, to, wherever possible, not engage with the anti-vaxxers but instead try to understand and address the causes of vaccine hesitancy. As I have set out above at paragraph 32 in relation to localised vaccine disinformation, I agree that to have publicly engaged with any misinformation, could have risked legitimising it. I do not believe that we were excluded from the discussion on the part of vaccine hesitant groups, but rather careful to ensure targeted but comprehensive information was easily accessible to those with questions or doubts. The approach taken to communicate the evidential basis of the vaccine through scientist and clinicians, rather than politicians, helped insulate the information from any perceived political association and therefore more effective in dispelling any myths amongst those with a distrust of Government. I believe the campaigns to increase confidence in the COVID-19 vaccines

were effective in identifying the groups that were more likely to be hesitant to provide targeted communications through trusted individuals within the scientific and medical professions and leaders from within their communities. I am confident that it was through this work that we were able to maintain some of the highest rates of vaccine confidence in the world throughout the pandemic.

Vaccine as a Condition of Deployment (VCOD)

193. For a summary of the Vaccine as a Condition of Deployment Scheme, I refer the Inquiry to paragraphs 246 to 252 of the Eighth Witness Statement of Sir Christopher Wormald dated 30 August 2023.

194. Decision-making around the VCOD policy is also summarised at paragraphs 144 to 160 of the Further Witness Statement of Jonathan Marron and Michelle Dyson for Module 2 dated 12 October 2023.

My role

195. Anticipated lower vaccine uptake in care home and healthcare workers had been central to early discussions on driving vaccine uptake. Following the public commitment to offering COVID-19 vaccines to all care home residents by the end of January 2021, there was a sharp focus on the workers themselves to ensure this did not create a gap in protection for some of the most vulnerable people to the virus. This was the subject of a submission that I received on 22 January 2021, which recommended that the focus at national level should be on persuasion and incentivisation, rather than regulation. It noted that a Task and Finish Group had been established to deliver an action plan to tackle vaccine hesitancy in the social care workforce and would be informing the Government's approach, taking account of the rapidly evolving situation **(NZ1/153 - INQ000479184).**

196. On 26 January 2021, Minister of State for Social Care, Helen Whately, and I provided our joint approval of the submission, noting that we, along with the Secretary of State for DHSC wanted to be kept informed on any significant options that the Task and Finish Group developed **(NZ1/154 - INQ000479189).**

197. On 28 January 2021, following amendments made by Helen Whately, I provided my further input to a note to the PM setting out the options proposed to drive uptake and set out a plan to do the groundwork for making vaccination a condition of work in the health and social care **(NZ1/155 - INQ000479193)**. I emphasised the importance of engagement with care homes as there was anecdotal evidence that staff uptake had improved after repeated visits **(NZ1/156 - INQ000479194)** Helen Whately's amendments highlight a need to consider extending any policy to frontline NHS workers if we receive evidence that vaccination reduces the risk of onward transmission. At the time, I agreed with this in principle and thought it should be explored, although subsequent advice setting out the rationale for focussing on social care workers made it clear to me that an extension of the policy to frontline NHS workers at that time could have been disproportionate, when balanced against the individual rights of staff and other potential negative impacts of the policy. There was a higher uptake of the vaccine among frontline NHS workers so any enforcement action would have little benefit and could risk alienating people further. To illustrate, I set out a summary of this rationale as set out in a COVID-O paper that I received on 16 March 2021 **(NZ1/157 - INQ000499501) (NZ1/158 - INQ000499502):**

a) While rates of vaccination in care homes were increasing, they were not rising fast enough to reach the levels of safety, advised by SAGE (each care home to vaccinate 90% of residents and 80% of staff). As lockdown restrictions were due to be eased; regional variation was too great, with London, in particular, lagging other regions (with only 21% of care homes reaching this dual threshold);
b) The age of care home residents also made them particularly vulnerable to COVID-19. The average life expectancy in UK care homes was 24 months for care homes without nursing and 12 months for care homes with nursing. The Joint Committee on Vaccinations and Immunisation (JCVI) identified residents in older adult care homes, and their carers, as the top priority group in programme for vaccine rollout;
c) In addition, the closed nature of care homes increased the risk and impact of COVID-19 outbreaks

198. On 18 March 2021, I was copied into the COVID-O actions from their meeting on 17 March 2021 **(NZ1/159 - INQ000091817).** The Committee agreed to the proposals in the paper for DHSC to continue to develop public consultation and proposals to take forward secondary

legislation to make vaccination a condition for deployment for staff in older age residential care. It was also agreed that DHSC would continue to work to increase vaccine uptake amongst both health and social care workers through all possible non-legislative routes.

199. On 27 May 2021, I received an update on the consultation on whether to make the COVID-19 vaccine a condition of deployment in care homes with older adults which had closed on 26 May 2021, with over 13,000 responses received **(NZ1/160 - INQ000499505) (NZ1/161 - INQ000328130)**. Subject to consideration of the remaining consultation responses, the submission required initial approval on the scope of the policy, setting out the options considered, and rationale for ultimately recommending the following:

    1. The scope of the initial policy should extend to all CQC registered care homes
    2. The condition should apply to all people working in a care home setting including visiting professionals (NHS and trade workers etc.)
    3. The scope of, and process for, exemptions should align with the approach proposed for COVID certification, subject to further refinement based on clinical and legal advice.
    4. A grace period of at least 12 weeks should be included so that providers can ensure most existing staff are able to meet the condition, to reduce impact on workforce supply and continuity of care and to reduce risks under employment law.
    5. An extension to wider health and social care settings should be considered (including domiciliary care, and drug and alcohol residential services) as part of a further consultation.

200. A draft PSED was prepared on the basis of the above recommendations, noting that an updated version of this would be provided in the submission seeking approval of the draft Regulations (which I was not a party to but is referred to in the above extract from the Further Witness Statement of Jonathan Marron and Michelle Dyson for Module 2 dated 12 October 2023) **(NZ1/162 - INQ000499506)**. The draft PSED identified that the policy would likely have a significant impact on people from a range of protected characteristics and set out a number of possible mitigations.

201. On 27 July 2021, I provided approval for the scope of a draft consultation on VCOD in healthcare and wider ASC settings and for this to be shared with trusted stakeholders **(NZ1/163 - INQ000479242)**. As part of this decision, I considered the impacts of the policy on black and minority ethnic groups under my Public Sector Equality Duty (PSED). It was noted that both the health and social care workforces are female dominated, with a strong representation for non-white ethnicities relative to the UK-wide population. I was also aware that Black, Asian and Minority Ethic people, and women, particularly of childbearing age, had significantly higher levels of vaccine hesitancy compares to the rest of the population. It was clear that these two groups were most likely to face a disproportionately negative impact as a result of the policy and its subsequent operational delivery.

202. I believe the likely negative impacts of the policy on certain groups of people were carefully considered. I accept that in some cases, there were identified risks of substantial impact but, in balancing these against the clear public health rationale for driving vaccination uptake in care homes, I provided my approval to the policy. I agreed with the principle that those who, through their job, come into regular contact with the elderly and vulnerable owe them a professional duty to protect their health. I agree with Jonathan Marron and Michelle Dyson that there is a balance to be struck between the individual rights of staff and the need to protect the vulnerable. Where there are no reasonable ways to effectively prevent transmission other than by vaccination, requiring staff to become vaccinated will, at times, be proportionate. I believe the decision at the time was proportionate and supported by the clinical evidence at the time based on the severity of the Delta variant, as referenced by Sir Christopher Wormald in the extract above. Although the policy came into effect after I left the role of Minister for COVID-19 Vaccine Deployment, I understand that the effectiveness, ethics and any adverse effects of the policy were kept under review as cited in the extract above. The fact that a proposed expansion of the policy was not pursued and then the policy itself ultimately withdrawn shows, I believe, the way Government was responsive to the changing need for such a protective measure where the population was better protected against the new Omicron variant.

Vaccine safety

203. For a summary of the safeguards that exist that ensure both the independence and impartiality of the MHRA, I refer the Inquiry to paragraphs 71 to 76 of DHSC Statement A.

204. For a summary of how the MHRA ensures that vaccines meet applicable safety standards and identifies any associated risks before and after authorisation, as well as how DHSC, on advice from the JCVI, dealt with any possible risks, I refer the Inquiry to paragraphs 213 to 238 of DHSC Statement C.

The MHRA Yellow Card system

205. As set out in the above extract, the MHRA encourages the reporting of any side effects to its Yellow Card system and provided a dedicated coronavirus Yellow Card site for healthcare professionals and patients to report suspected side effects of the COVID-19 vaccines **(NZ1/164 - INQ000411797).** Professional guidance on both blood clotting and Guillain-Barre Syndrome (GBS) following COVID-19 vaccinations specifically highlighted importance of reporting all suspected cases to both the Yellow Card scheme and to UKHSA's clinical reporting scheme **(NZ1/165 - INQ000354573) (NZ1/166 - INQ000411739).**

206. On 6 October 2021, the MHRA invited participation from health professionals in supporting its annual social media campaign to raise awareness of the Yellow Card scheme, #MedSafetyWeek, which would take place between 1 and 7 November 2021, **(NZ1/167 - INQ000479248).** The theme for the 2021 campaign was the importance of reporting suspected adverse reactions to vaccines in particular. The announcement set out ways that professionals can raise awareness of the scheme amongst colleagues and remain vigilant for new or rare suspected reactions to the COVID-19 vaccine and report them to the MHRA. It also encouraged professionals to support its social media campaign by sharing MHRA social media posts and posting their own material using the #MHRAyellocard, #MedSafetyWeek, #ReportSideEffects, and #patientsafety tags on social media. I cannot recall specifically, but I believe this was the 'targeted social media campaign' I was referring to in my letter dated 9 August 2021 to Sir Geoffrey Clifton-Brown MP. I am not aware of any assessments that were undertaken as to the effectiveness of the campaign as it was led by the MHRA.

The Vaccine Damage Payment Scheme (VDPS)

207. For a summary of the Vaccine Damage Payment Scheme (VDPS), the rationale for inclusion of COVID-19 vaccines in the VDPS, the challenges to its inclusion and how these were overcome and proposals for reform, I refer the Inquiry to paragraphs 239 to 271 of DHSC Statement C.

208. On 1 December 2020, I received a submission **(NZ1/168 - INQ000257411)** seeking my signature of The Vaccine Damage Payments (Specified Disease) Order 2020 (**NZ1/169 - INQ000257415)** to add COVID-19 to the list of diseases covered by the VCDPS by amending the Vaccine Damage Payment Act 1979, as set out in the extract above. Accompanying the submission was a suite of supporting documentation to the policy including an Impact Assessment (**NZ1/170 - INQ000292597),** and analyses of the PSED **(NZ1/171 - INQ000257416)** and Family Test **(NZ1/172 - INQ000257417**). I approved the Order on 2 December 2020 **(NZ1/173 - INQ000479151).**

SECTION SIX: LESSONS LEARNED

209. With the benefit of hindsight and, in consideration of the particular challenges that I faced as Minister for COVID-19 Vaccine Deployment, I agree with the DHSC five lessons as set out in relation to the matters identified within this module at paragraphs 329 to 359 of DHSC Statement A. For a summary of lessons learned regarding public messaging, I refer the Inquiry to paragraphs 191 to 194 of DHSC Statement C, with which I agree.

210. I agree that the Technical Report continues to be a valuable source of information when reflecting on lessons learned. The February 2021 NAO Report has also been particularly useful to my own reflection in preparing this statement. It is clear that, despite a general increase in COVID-19 vaccine confidence and overall uptake exceeding expectations, there is still work to be done to address disparities. Lower vaccination rates in some groups persist despite the national and local efforts to address inequalities as set out above. Although it is difficult to isolate which measure had the greatest impact, I have identified some examples below within identified key innovations that I believe should be continued as part of any future projects to address disparities in vaccine uptake.

211. I feel unable to provide any valuable insight on the current state of contingency plans for the UK's ability to promptly vaccinate the whole population in a future pandemic. In September 2021, when I left the role and moved to the Department for Education, although the structures that held it in place were well established, the rollout was still in progress. We had integrated much of our learning into the programme already but, given the continuing uncertainties of the pandemic, at the end of 2021 it was too early to fix a comprehensive approach for the future. Since leaving the role, I have had no involvement in any contingency plans so my knowledge of the UK's readiness to vaccinate the whole population in a future pandemic is limited. I also think it would be difficult to compare any future plans with the situation I inherited in November 2020. The vaccines had been sourced, contracts for supply were agreed, structures were in place for the imminent rollout; we were already in a position to promptly vaccinate the whole population. Those that laid the groundwork would be better placed to understand how best to prepare and maintain such plans to scale up vaccinations at the pace that was needed. That said, I hope the insights I provide below will go some way to identify lessons that can be learned to better prepare for large-scale vaccination at pace for future pandemics.

212. I set out the following innovative ways in which we worked which I believe added particular value to the vaccine project and how I think they could be built on for the future:

a) The use of data;
b) The use of existing local resources and networks;
c) The integration of operational experience within Government;

The use of data

213. The data from the Foundry platform that showed daily figures on both the timing and location of vaccinations as well as the demographic of those vaccinated was key to the programme's success. The highly granular data allowed us to closely manage each aspect of the programme and quickly and accurately respond to problems as they arose. This not only supported us in distribution, enabling us to track how vaccine stock was being used and, where disparities arose, to redistribute supply, it also helped build public confidence and supported our efforts to address disparities in uptake.

214. My ability to understand and share clear data with the executive and the public with complete transparency was the most efficient way to build confidence in the project. As I have already highlighted, vaccination data moved from weekly to daily publication at my insistence and without requiring additional resources, thanks to the daily breakdown of data already available to us through the Foundry platform. I believe that in times of crisis, transparency is key and believe that the gathering and publication of data should be a priority in managing any future national emergency.

The use of existing local resources and networks

215. One way in which we adapted our approach in response to lessons learned at the time was through placing increased focus on local resources and networks. For example, it soon became clear that vaccinations through GPs and pharmacies not only made the vaccine more accessible, it also saved money at £24 per dose compared with £34 per dose from a vaccination centre. In the period of 8 December 2020 to 30 September 2021, 70.8% of vaccine doses had been delivered at Primary Care Network and pharmacy sites **(NZ1/174 - INQ000499510)**. This was a reflection of the way the team utilised existing local infrastructure and capitalised on the trust that communities placed in their local professionals and leaders. This change in approach was key to addressing one of our greatest challenges; addressing vaccine inequalities in historically marginalised and ethnic minority communities.

216. On 7 January 2021 I attended a meeting with Jo Churchill, Kemi Badenoch and representatives from the National Pharmacy Association **(NZ1/175 - INQ000477623)**. We explored ways to build on the role of community pharmacies to promote uptake of the vaccine as well as their wider role in the vaccination programme. We discussed ways in which we could utilise the existing pharmaceutical supply chain to deliver the vaccine and associated consumables, such as needles and swabs, to relieve the burden on the NHS. The limitations of deploying the Pfizer vaccine within pharmacies were noted and it was suggested that the AstraZeneca vaccine would be more suitable. I told attendees that although we were agile and able to bring a service online quickly, it would be helpful to have time to plan and prepare so that once more supply of the vaccine became available, pharmacies would be ready to deliver. A number of next steps were agreed in relation to how NPA would help facilitate the involvement of pharmacies in the promotion and

deployment of the vaccine. I do not recall any specific action that was taken by my team in relation to the information shared but I am confident it would have fed into our more general strategy to make greater use of pharmacies as early as possible. I think it important to note that I do not believe that our use of community pharmacies was limited by any lack of action to prepare the network for deployment; I believe our greatest hurdle in the beginning was the insecurity of supply.

217. Utilisation of the pharmacy network in the early phases of the roll-out must be considered in the context of availability of the vaccine at the time. In the interest of deploying the vaccine to as many of the earlier cohorts as quickly as possible, there was a need to strike a balance between management of the supply chain and operational issues within the pharmacies and surgeries on the ground. Earlier on, where supply was scarcer, and the need to vaccine the most vulnerable members of society stronger, it was vital that every vaccine was deployed as quickly as possible. Operational teams would need to be sure that pharmacies had the facilities to receive, store and deploy the vaccine safely and reduce the risk of waste wherever possible. Mass vaccination centres were more efficient in high volumes and could more easily absorb any fluctuations in the supply chain. As confidence in the supply chain grew, we were able to put smaller sites, such as pharmacies and GP surgeries, to greater use and reap the associated benefits of greater accessibility.

218. In a perfect world, with no supply chain issues, I would advocate for greater use of pharmacies earlier on, but I believe we responded with agility to the changing situation, keeping the situation under constant review, and made good use of the resource as quickly as possible in the circumstances.

219. Another example of this approach was with the deployment of Hatzola ambulances to administer the vaccine in the Orthodox Jewish community, using local resources and volunteers that put a trusted face to the vaccine and were better placed to meet the needs of local communities. The repurposing of existing local infrastructure made efficient use of buildings and resources that were, at the time, largely out of use but it also had the added benefit of gaining greater trust and confidence in the community. As with GPs surgeries and pharmacies, local places of worship, with endorsement by local faith leaders, gave further

legitimacy to the vaccination programme to communities that may have been more resistant to public health campaigns coming from Central Government.

220. I believe that the adapting of existing local infrastructure and resources was key to our ability to deploy the vaccine at such scale so quickly. Equipping local GPs, pharmacies and volunteers, who are much better placed to understand and address the issues specific to their community, is central to this purpose. In preparing for any future public health crisis, emphasis should be placed on empowering local networks.

The integration of operational experience within Government

221. As I have noted throughout my statement, the VTF leadership roles were filled with highly skilled and experienced individuals, many of whom had been appointed from industry roles and were used to working in a world that relied on risk-taking and creativity. Some had come via senior operational roles within different sectors of the civil service and were used to managing large private sector contracts in areas such as logistics and supply chain. I have already stated the importance of creating a productive working environment by removing the distraction of external questions, which formed a large part of my role. The lack of confidence from Central Government was in part, I believe, due to structural inefficiencies that would be better served by the creation of an effective Chief Operating Officer role for each department with the CO.

222. It is important to retain knowledge and experience within Government as much as possible to effectively scale-up projects such as vaccination programmes in the event of future pandemics. Rather than the creation of a reserve list, for example, I believe knowledge would be better retained by the appointment of an operationally competent individual within the CO who knew and understood operations within their department and could help the Government make informed decisions at pace.

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: 22/08/2024