Monday, 27 January 2025

(10.30 am)

LADY HALLETT: Morning, Mr Mansell.

MR MANSELL: Good morning, my Lady. The first witness is Darius Hughes, please, if the witness can be sworn.

MR DARIUS HUGHES (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR MANSELL: Could we start, Mr Hughes, by you giving the Inquiry your full name, please.

A. Darius Bruce Hughes.

Q. Thank you very much, Mr Hughes, for coming here today to assist the Inquiry. And thank you for the witness statement you have provided for the Inquiry, it's INQ000474453, and that witness statement is provided by you on behalf of Moderna; is that right?

A. Correct.

Q. That statement is signed by you and are the contents of it true to the best of your knowledge and belief?

A. They are.

Q. I'd like to ask you a few questions about Moderna and your professional background with that company.

Moderna, you describe as a group of companies and the first Moderna company was founded in 2010 by scientists as a biotechnology start-up company and a pioneer in the development of messenger RNA vaccines

and therapeutics?

A. That's correct.

Q. In fact, the Moderna name reflects that founding principle combining the words "modified" and "RNA"?

A. Yes.

Q. The ultimate group parent company is Moderna Incorporated, which is headquartered in the US?

A. Yes, in Cambridge, Massachusetts.

Q. You explain you joined Moderna Biotech (UK) Limited in July 2021 as general manager for the UK.

A. Correct.

Q. And that's your current role; is that right?

A. Correct.

Q. And when you joined in July 2021, you were only the second employee, and you recruited the initial UK team?

A. That's correct.

Q. Moderna, as we've heard, produced a Covid-19 vaccine, which was initially known as mRNA-1273, and later by the name Spikevax?

A. Correct.

Q. And that vaccine was procured by, and rolled out in, the UK?

A. That is correct.

Q. You note this in relation to Covid-19 vaccines: that it's estimated by the World Health Organisation that

over 13 billion Covid-19 vaccine doses have been administered worldwide, and more than 70% of the world's population have received at least one dose?

A. Yes.

Q. And you explain Moderna has supplied approximately 1.5 billion Covid-19 vaccines to date globally?

A. Correct.

Q. I want to ask you next about the development of the Moderna vaccine. Is this right: that when the pandemic arose, Moderna had already been conducting foundational research into the field of mRNA-based drugs for a number of years? Is that right?

A. That is correct.

Q. And that was in particular in the field of other coronaviruses, including MERS and SARS?

A. That's correct, yes, since 2010, when the company was first inaugurated, they'd been working on messenger RNA, and most recently they'd been working with the National Institute of Health in America on MERS and other SARS viruses.

Q. And then, when the pandemic hit, there was a pivot in terms of that technology to focus on Covid-19?

A. That is correct, yes. We would already have been asked by the National Institute of Health to do an exercise, as it was then, to look at a possible pandemic flu, and

instead of performing that exercise, the company pivoted to the SARS-CoV-2.

Q. The development of the initial Moderna Covid-19 vaccine, including all clinical trials, took place in the United States; is that right?

A. That is correct.

Q. And that was expedited under Operation Warp Speed, which was the US government's co-ordination project to accelerate the development of vaccines?

A. That's correct, yes. The National Institute of Health and the Operation Warp Speed, which was very similar to our Vaccine Taskforce, were working in collaboration with Moderna to accelerate that through, yes.

Q. In terms of clinical trials for the Moderna vaccine, did they have to meet the same requirements and approvals as if conducted in non-pandemic circumstances?

A. Absolutely. All of the -- exactly the same criteria.

Q. I want to focus on the pivotal phase III trial which took place around 27 July 2020. And that enrolled more than 30,000 participants; is that right?

A. Correct.

Q. Was that trial eventually relied upon by Moderna as part of its package for authorisation in the UK?

A. Yes, that was one of the key parts of the package, yes.

Q. A concern raised by some Core Participant groups is the

ethnic diversity of clinical trials and whether they were sufficiently diverse, because the point is that if they're not sufficiently diverse, in terms of ethnic background, there may be a lack of confidence amongst certain groups when it comes to rollout.

You explain in your statement that the trial, the phase III trial, included more than 11,000 participants from ethnic minority communities, representing 37% of the study population. And we can see more detail in a paper published in the New England Journal of Medicine, it's INQ000408427.

This is a paper regarding the phase III trial results dated 30 December 2020. At page 1 there, at the bottom of the page, "Conclusions", we can see this:

"The mRNA-1273 vaccine showed 94.1% efficacy at preventing Covid-19 illness, including severe disease. Aside from transient local and systemic reactions, no safety concerns were identified."

So no suspected unexpected serious adverse reactions during the trials?

A. Correct.

Q. And no SUSARs in relation to cardiac events?

A. None.

Q. We can turn next, please, to page 6 of this article. And we can see on that page a section -- actually just

above that section, please, we've got "Hispanic or Latino ethnicity", and we've got the percentages there and the number of participants: "Hispanic or Latino", 20.5%, 6,235 of the trial participants.

And then the next box, please:

"Race or ethnic group ..."

We have a breakdown of the number of participants there, with "Black or African American", for example, making up 3,090 participants, 10.2%.

Can you help us, please, as to why the figures are broken down with a separate section in this table for Hispanic or Latino ethnicity?

A. It's my belief that that is the standard practice of the federal drug administration in the US, because it reflects greatly the population and the -- of the United States.

Q. But when we're looking at your figures, the 11,000 participants from ethnic minority communities representing 37% of the study population, we must include the Hispanic or Latino group of people within that figure; is that right?

A. That is correct.

Q. That can come down, thank you.

In your statement you explain that Covid-19 had a disproportionate impact on relation and ethnic

minority communities, and in recognition of that, you slowed enrolment for the phase III trial to ensure representation. How did slowing enrolment help ensure representation?

A. So, as you have stated, the phase III clinical trial was run in America. It was run across around 200 sites across America, and these sites are spread widely across the whole of the United States. And we monitor on a daily basis the number of patients that are being enrolled to the study. And some of the study centres had already got to their quota and they were predominantly white and some of the study centres hadn't got to their quota. And instead of continuing the study centres that were predominantly white, we stopped recruitment there and slowed down the overall recruitment of the 30,000 patients and waited for the study centres that were predominantly black, Hispanic and Asian to catch up, so we got a fair representation of the population across of the whole of the United States that would be getting this vaccine.

Q. Did it work? We've seen the figures, 10.2% black or African American participants in the trials, for example. Did the steps you took ensure representation? Is that representative of the population level demographics in the US?

A. Yes, it is.

Q. We are, of course, focused on the UK, and from an industry perspective, what, if anything, could be done in the UK to ensure a greater ethnic diversity in clinical trials?

A. Yeah, I mean, I think the ethnic diversity in the clinical trials in the UK is on a progressive way forward. I think that a lot of work has been done over the number of -- couple of years to really increase that ethnic diversity.

What we have found in Moderna, we are one of the largest sponsors of clinical trials in the UK, with about one in five of all clinical trials in the UK in 2024 being Moderna trials. And what we've found is we've done a couple of different things. One is to try and get the -- bring the clinical trial to the people, to the individuals. So, rather than having them in big hubs or in big hospitals, we try to go out to the population, into local GP surgeries, we're doing a trial with Boots the Chemist, we're also going into some faith areas and places like that to try to get the participants to broaden participation.

And the other thing we're trying to do is the way we communicate with participants. So, rather than making it quite bland and quite reactive, where the

participants have to go and find out a lot of the information themselves, we're trying to be a little bit more inclusive in the way we communicate and getting people that they're going to listen to, faith leaders, people in their communities, to actually talk to them about those clinical trials.

Q. Other groups, pregnant and breastfeeding women were excluded from the pre-authorisation clinical trials?

A. That is correct.

Q. Immunocompromised individuals also excluded?

A. That's correct.

Q. Vaccination was subsequently recommended for those groups, for example you note that public health groups recommended and continue to recommend vaccination for patients who are immunocompromised although there was an observed reduced immune response in that group. Is there a case for including such groups in pre-authorisation studies so that randomised controlled trial data can be gathered about them prior to rollout?

A. So for Moderna we're very, very keen on including and having a very broad, diverse population, both in our clinical trials and in our post-observational trials. It's very compelling that we have the right vaccine tested on the right populations that are going to use them, so we would be very supportive, should the

regulatory authorities decide to do so, in changing the way that the clinical trials are designed, and would be very supportive in helping to ensure that this is more representative going forward.

Q. Would it help, would it assist, to understand how those groups are going to respond, or are there difficulties in recruiting, particularly pregnant women that need to be overcome?

A. I think traditionally it is very difficult to recruit pregnant women and also some of the more immunocompromised patients just because, you know, there's a nervousness, I suppose, about being involved in something that is new, that is experimental. I think there is a lot of work that would need to be done but I think it is work that Moderna is prepared to engage in and get behind the regulators on.

Q. Trials in the UK, in October 2020, there was a suggestion that some of the clinical study work for the vaccine could be conducted in the UK. Is this right: that the UK was a particularly attractive place to conduct clinical trials because of the integrated system between the NHS and the MHRA?

A. That is correct, yes.

Q. That trial, you explained, did not go ahead because the number of Covid-19 infections in the UK decreased over

the summer of 2020. However, in 2022, I think, there were clinical trials conducted in the UK for the Omicron-targeting bivalent vaccines; is that right?

A. That is correct.

Q. Bivalent means protecting against the original virus and a later variant?

A. That's correct, yes.

Q. In relation to that trial you say that the UK Government encouraged pharmaceutical companies to share clinical trial sites because there were a limited number of such sites approved to conduct clinical trials in the UK.

Was this a problem? Would it have helped if there had been more such sites?

A. It wasn't a problem, no. I think the sites are very few in number because they are centralised on those hospitals that I was describing earlier so it wasn't a problem at the time. The sites are very well run. They get a lot of patients through the door and we were able to conduct our trial very efficiently. We enrolled over 3,500 patients in a very, very short period of time. There was still a lot of public enthusiasm in joining those kind of trials.

So it wasn't a problem no.

Q. You do, however, note that there are possible lessons that can be learnt regarding vaccine development and

approval, particularly in relation to harmonisation across jurisdictions. You note that formal harmonisation across jurisdictions regarding data requirements from clinical trials would help in trial study design, and pre-defining a simplified data package structure for submission to regulators for pandemic-specific products would also be helpful.

Is this something that we need to look at in the UK: whether or not it would assist to have these pre-determined pandemic authorisation processes mapped out for manufacturers?

A. Yes, I think it would be very useful, and it's not just in the UK. I think the point is that this could be harmonised more across the whole of the world.

Q. Next topic: authorisation of the Moderna vaccine. Initial MHRA authorisation for the vaccine was under Regulation 174 of the Human Medicines Regulations 2012; that was on 8 January 2021?

A. Mm-hm -- yes.

Q. This followed earlier authorisations by the FDA in the United States, authorisations in Canada and Israel, and then the European Union on 6 January 2021?

A. Correct.

Q. However, you explain that Moderna did not supply any of its vaccine under Regulation 174, instead applying for

a Great Britain Conditional Marketing Authorisation through the European Commission Decision Reliance Procedure (ECDRP).

Why was that route preferable when it actually came to supplying the vaccine in the UK, as opposed to Regulation 174?

A. In early 2021, when Moderna received the Reg174 approval, we weren't actually ready to manufacture and deliver those vaccines into the UK, and our target for delivering those vaccines was 1 April.

So it was agreed between the MHRA and our regulatory teams that we would focus on the European Commission Decision Reliance Procedure that would allow us to really get the data correct and focus on that and focus on our manufacturing and getting all of those scale-ups ready so that we would be ready for 1 April.

Q. And the reliance procedure, that's where you get a CMA from the EMA, from the European Medicines Agency, and had maps across and is utilised by the MHRA in a fast track procedure for authorisation in the UK; is that right?

A. That is correct.

Q. You note that:

"Approval under Regulation 174 did not allow for details to be amended in the Marketing Authorisation or

in the manufacturing process. It did not allow for the upscaling of manufacturing or any flexibility in the supply chain."

So these were limitations on the Regulation 174 route, were they?

A. 174 is a relatively tight regulatory statutory instrument, and every time you make a change, you have to make a change to the Regulation 174. But of course, we were also making changes to our Conditional Marketing Authorisations through the EMA and through the FDA, so it was really the fact that it was duplicating the amount of work that would have to be done. And in the time when the MHRA were very busy reviewing a lot of work, Moderna were also very busy focusing getting the delivery, it was deemed a better use of everyone's time really to focus on that Conditional Marketing Authorisation through the ELA (sic).

Q. We've hearing about expedited processes when it comes to authorisation, rolling review. Were any of the authorisation processes applied by the UK from Moderna's perspective, less stringent when it came to assessing safety?

A. Not at all. The stringency was as it was for any other application.

Q. You explain in your statement that due to the scale of

the rollout, there was a huge amount of post-authorisation data generated about the Moderna vaccine in a short amount of time. You say that the same amount of data was generated in less than one year than might be expected from an influenza vaccine in use for 20 years.

You also explain that that huge volume of data allowed a clearer view of the safety profile of the vaccine to be reached more quickly.

A. That's correct.

Q. And that's what I want to turn to now, please. And we'll start with the risk management plan, because it's a requirement, isn't it, that Moderna had to submit and update as necessary a risk management plan for the vaccine.

A. That's correct.

Q. And that document sets out Moderna's overarching pharmacovigilance plan, which identifies potential risks and safety concerns, and the risk minimisation measures that Moderna is going to put in place.

You've exhibited version 1.1 of the EU risk management plan, but was this also applicable in the UK --

A. Yes, it was.

Q. -- because of the reliance -- (overspeaking) --

A. Yes, it was.

Q. Let's have a look at that now then, please, INQ000398107.

This is dated 1 March 2021.

And we can turn to page 47, please.

Here we can see "Routine Pharmacovigilance Activities". It says:

"[They] will be conducted for mRNA-1273 along with the additional actions part of the pharmacovigilance plan."

Talks about:

"... special circumstances of the pandemic, enhancement of routine activities ..."

Having:

"... a safety surveillance and reporting system in place to organize the collection, data entry in the company global safety database ...

"A call center ... available in countries for vaccine providers ..."

And "follow-up" for serious adverse events, including hospital records, autopsy reports, and querying matters with the reporter, as possible.

Page 49, please.

We can see here a table setting out "Vaccine Signal Data Sources and Frequency of Evaluations": company

Global Safety Database, weekly literature review, a continuous monitoring of EudraVigilance, which we know is the system for managing and analysing information on suspected adverse reactions to medicines which have been authorised or been studied in clinical trials in the European Economic Area. And VAERS, is that Vaccine Adverse Event Reporting System? Is that a US system?

A. Correct.

Q. And health authorities websites, reviewing those.

That can come down, please.

In terms of those requirements, any less stringent than non-pandemic times?

A. No, not at all. It was a fairly standard process. Moderna has got a very large global safety and pharmacovigilance team and they would be monitoring those. In fact, I think during the pandemic it was even heightened in terms of level of vigilance that we were doing.

Q. Let's just go through some of those requirements, then, at a high level but -- reviewing and assessing safety data from all external sources?

A. Correct.

Q. Maintaining a Global Safety Database; we've seen that?

A. Yes.

Q. Reporting information that Moderna receives about

adverse events to the MHRA?

A. Yes.

Q. The Moderna pharmacovigilance team downloading reports generated by the MHRA on the Yellow Card system --

A. That's correct.

Q. -- and using that as part of your analysis?

A. That would then go into our global safety database, yes.

Q. We've seen reviewing and evaluating relevant medical publications and peer-reviewed journals?

A. Mm-hm.

Q. Is it right that Moderna held regular meetings with the MHRA and provided summaries of evaluated safety data to the MHRA?

A. That is correct. Those meetings were weekly in the height of the pandemic, and was very, very stringent, and we carried on doing those for quite some time.

Q. And in fact is this right: that those reports, the summaries of evaluated safety data, they were provided every six months for the first two years to the MHRA --

A. Actually, every month for the first six months, yes. Which is unusual. Normally, it is only every six months.

Q. So there was a heightened requirement in that regard?

A. Yes.

Q. And is it right that Moderna also undertook an

obligation to undertake post-authorisation safety studies or PASS, something that we've heard about?

A. That is correct, yes. We are undertaking eight interventional studies and eight non-interventional studies.

Q. In terms of the difference between them, could you just explain that, please, the difference between interventional and non-interventional?

A. An interventional study is a bit like a clinical trial where there will be some sort of patient involvement, whereas a non-interventional study would be really looking at the literature and pulling together external data.

Q. So 16 PASS; how many published?

A. So the interventional studies, four have published, it says two in my statement but two more have been published since my statement was done; and for the non-interventional studies, one.

Q. Why not more published?

A. It's just the length of time that it takes for them to run. So a lot of these studies, particularly the observational studies, the non-interventional studies, are going to be going on for one, two, three years and follow-ups of all the patients and data collection. So it just takes a long time to run them.

Q. You may have seen the evidence of Professor Prieto-Alhambra, one of the Inquiry's safety experts?

A. Yes.

Q. In his report, he recommends greater obligations on pharmaceutical companies to conduct early post-authorisation safety studies with a particular focus on ethnic minorities, elderly people with frailty or multiple comorbidities, pregnant women, and people with disabilities. What is Moderna's view of that recommendation, greater obligations on the pharmaceutical industry?

A. So Moderna's priority is always the safety of our medicines and vaccines, and as such, we would be happy to collaborate and work with the regulatory authorities on any of the requirements for post-authorisation studies that they deemed appropriate.

Q. Is it required?

A. At the moment, no.

Q. Let's look at a particular risk associated with the vaccine now, myocarditis and pericarditis. And I want to focus on that, please. It was monitored as an adverse event within the clinical trials. Is that because it's a known risk of vaccines?

A. That's correct, yes.

Q. But not observed, you've explained. In February 2021 the Israeli Ministry of Health received reports of myocarditis post-vaccination with the Pfizer mRNA vaccine and initiated active surveillance?
A. Yes.
Q. Then as of May 2021, you explain there were 19 reported cases of myocarditis among people who received the Moderna vaccine, and an additional 19 cases of pericarditis, and that was out of a total of approximately 20 million doses of the vaccine that had been administered by that point.
A. That is correct.
Q. Was assessing the safety signal in relation to myocarditis and pericarditis complicated by the fact that Covid-19 can cause those conditions itself?
A. It was.
Q. And how was that addressed? How was that dealt with?
A. Well, the processes where we assess all of the data that's come in in our global safety system and work very closely with the regulators. I think it was unprecedented the way that the information was shared. So when the initial signal came out in Israel, that was, indeed, from the Pfizer-BioNTech Covid vaccine, but that data was shared across all of the regulatory authorities, it was shared with us as well, and it

allowed us to go and then really do a deep investigation into our safety studies and into the global database that we had. And the European Medicines Agency as well, they were able to do it.

So it was a very close collaboration across all the agencies, all the companies, that came to those conclusions.

Q. Did that lead to the summary of product characteristics and product information being updated in relation to Moderna on 25 June 2021?
A. It did.
Q. And we can see, please, INQ000398119, and page 4, please. So this is the summary of product characteristics, and it says there at the bottom of the page:

"Myocarditis and pericarditis

"There have been very rare reports of [those conditions] occurring after vaccination ... often in younger men and shortly after the second dose of the vaccine ... typically mild cases and individuals tend to recover within a short time following standard treatment and rest."

And there's what healthcare professionals should be alert to, in terms of that.

Thank you, that can come down.

You explain that more extensive information was included in the summary of product characteristics on 15 June 2023, with myocarditis and pericarditis noted as "very rare", in terms of a possible side effect, in the patient information leaflet dated 25 September 2023; is that right?
A. Correct.
Q. And we can see that, please, this is the information provided to patients as of that date, INQ000398117, page 4, please.

"Very rare (may affect up to 1 in 10,000 people)

"- inflammation of the heart muscle (myocarditis) or inflammation of the lining outside the heart (pericarditis) which can result in breathlessness, palpitations or chest pains."

Is this right, that Moderna also prepared with Pfizer a Direct Healthcare Professional Communication in July 2021 about the risks?
A. That is correct.
Q. Can we see that at INQ00398124, issued by both companies. Page 2, please.

"Call for reporting

"Healthcare professionals are asked to report any suspected adverse reactions via their national reporting system ..."

Was this communication the result of a regulatory requirement?
A. It was, yes, from the EMA.
Q. But this document, although the focus is Europe, was also issued in the UK?
A. It was.
Q. There's no reference in this document to the Yellow Card Scheme, but there is a reference there to healthcare professionals reporting suspected adverse reactions through their domestic schemes.

That can come down, please.

In terms of the Yellow Card Scheme, does Moderna have a view on any recommendations for reforms or improvements to that scheme?
A. The Yellow Card Scheme is a very effective way of collecting adverse events from the healthcare professionals and from patients. I think the key to it is the speed with which we can get those adverse events back to Moderna and into our global safety database, and therefore we think that the digitisation of the Yellow Card Scheme as much as possible would be very, very helpful in getting that speed back. It would allow the MHRA to pass those safety events on much, much quicker.
Q. You note that it would have been useful to have more accurate data on the doses administered in order to

provide a denominator which is needed for calculating adverse event rates. Is that something you would have liked to have seen from the MHRA?

A. Yes. So the regulator doesn't provide the pharmaceutical companies with the number of doses that have actually been given into the UK population and in order to get the 1 in 10,000 or one in a thousand, it is very helpful to know, alongside the number of adverse events, the number of doses that have been given.

Q. You also note that it would have been helpful if anonymised demographic data had been provided to allow for calculating rates of adverse events in subpopulations. Was that information not available to you?

A. No, that information is not available, no. And again, it would be useful because then you could start to identify if these adverse events are occurring in a particular population.

Q. So this is information that could be captured through the Yellow Card Scheme. Is it the case that it's not captured or is it the case that perhaps people who are completing the yellow cards aren't filling it in?

A. In terms of the demographic, it's probably a case that people aren't filling it in properly. In terms of the number of vaccines given, that would not be collected

through Yellow Card, that would have to come from a different source.

Q. Turning now, please, to lessons learned and recommendations, and I want to focus first on the Moderna Innovation and Technology Centre, or MITC, because this is something you point to in the lesson learning section of your statement. This is a 10-year strategic partnership between the UK and Moderna?

A. That's correct.

Q. It includes the creation of the MITC, the Moderna Innovation and Technology Centre. That is planned to be an innovative vaccine research and manufacturing centre based in Harwell in Oxfordshire?

A. Correct.

Q. You explain the aim of the partnership is to enhance the UK's resilience against future pandemics and health crises by onshoring the production of mRNA vaccines and therapeutics against Covid-19 and other respiratory infections.

Now, we heard last week from Professor Dame Jenny Harries from the UKHSA that the MITC will be open in August of this year; is that right?

A. Around the end of August/beginning of September, yes.

Q. It will have capacity to produce up to 250 million vaccines per year in a pandemic?

A. That is correct, yes, it will be operational 24/7 with three manufacturing shifts that will allow us to provide enough vaccine doses for up to 250 million, should it be required.

Q. In a non-pandemic scenario, so from the time it opens, will it be manufacturing vaccines? Will it be kept warm, so to speak?

A. Yes, it will be. Yes, we will be operating it on one shift only, but we will be manufacturing doses in the UK for British patients. So for example, the Covid vaccine.

Q. So will that be as soon as that's online in August it will be -- or September it will be manufacturing vaccines from the off?

A. That is correct.

Q. Can you give us figures on the number of doses per year that you expect it to be producing in peacetime?

A. I mean, it's -- it will be available and can produce up to 100 million doses. I don't think that it will be required to produce that many but it is there, ready and available, both for pandemic setting and for non-pandemic setting.

Q. From an industry perspective, how will be partnership strengthen the UK's resilience in terms of onshore manufacturing?

A. Well, the partnership is made up of three main pillars. The first one is a pandemic preparedness pillar whereby we're working with cross-government agencies to understand the role that manufacturers would take in a pandemic, should another one be called. So we hope to really make that system a little bit more robust in terms of the decision-making processes and the roles and responsibilities. And then there's the manufacturing process where we're onshoring not just the manufacturing of the messenger RNA but the whole supply chain, so from the very, very beginning, so the bags and the bottles that we bring in, all the way through to the end, the vaccine being delivered into the NHS. That will all be onshored into the UK.

Then the third area we're working on is research and development. I mentioned earlier that we're doing a number of clinical trials in the UK, but we're also going to be doing a number of other things around research and development to really improve the ecosystem here and try and make the UK one of the leading places to do messenger RNA research in the world.

Q. So fill and finish capacity also included within this project?

A. That is correct, yes.

Q. We've heard evidence that the UK may be over-reliant on

mRNA as a vaccine modality and that we may be preparing for the next war, to continue that metaphor, on the basis that it's going to be the same as the last one. I don't know whether you have a view on that from an industry perspective?

A. I think that Moderna is only one part of pandemic preparedness, and that we will play our part but we need to look very broadly, yes.

Q. One other element on lesson learning, please, and that is the Vaccine Taskforce. In your statement you praise public and private sector synergy, is the word you use. You say that that occurred during the pandemic and was epitomised by the approach of the Vaccine Taskforce.

Would you like to see a similar body created in the event of a future pandemic?

A. Yes, I think I would. The responsibility that held the reporting structure and the mix of skills that were available on the Vaccine Taskforce were very, very helpful.

Q. One of the key aspects of that, we've heard, was bringing in industry expertise. Is it useful, during non-pandemic times, to have a body that ensures there is that industry expertise running all the time rather than waiting for a pandemic before it's established, do you think?

A. There are a number of industry bodies that already work very closely with the Department of Health and Social Care, and with the UK Health Security Agency. So there are a number of these that carry on in a non-pandemic time, and there are also a number of people who have industry experience who work at these government bodies.

MR MANSELL: Thank you, Mr Hughes.

My Lady, I believe Mr Weatherby KC has a question.

LADY HALLETT: He does.

Mr Weatherby.

Questions from MR WEATHERBY KC

MR WEATHERBY: Thank you very much.

Mr Hughes, I ask questions on behalf of the Covid Bereaved Families for Justice UK group.

Just two short questions from me. Firstly, you state for the record, paragraph 77 of your statement and I quote:

"There was a discussion between [the Vaccine Taskforce] and Moderna Switzerland ... about the early supply of the Moderna COVID-19 vaccine before the contracted supply date of 1 April 2021, but that could not be achieved in part because of the import and export requirements [as between the UK and EU] and the time it would have taken to resolve them."

Okay?

So my question is: has there been any change in the import/export requirements for vaccines since April of 2021 that would resolve those issues for the future? And if so, what are they?

A. So the requirements of import/export I don't believe have changed, but I think the challenge that we had originally was that Moderna wasn't really set up and ready to comply with the import/export authorisations that were required. It was a company that hadn't imported vaccines into the UK before, and so I think the challenge lay more with Moderna than it did with the rules and regulations.

Q. Right. Well, I mean, is there anything you can point to that could be changed which would improve that position now, or is it simply down to your processes?

A. So I think we got a lot better at doing that and have overcome those challenges. And of course with the onshoring of manufacturing, with the Manufacturing and Innovation Technology Centre, we won't have to do that in the future.

Q. I see. Well, that brings me on to the second point, and you may have answered this already, but let me just make sure.

You were asked a few minutes ago about the MITC, the innovation and technology centre at Harwell. How would

the UK's response to Covid-19, and in particular the development and products of vaccines, have been improved if that facility had actually been operational by the time the Covid-19 pandemic arrived? How would it have improved the actual delivery?

A. I mean, Moderna is very supportive of onshoring the production of medicines and vaccines into the UK. And our manufacturing and technology centre will indeed be ready and therefore some of the challenges that we had, with import/exportation, with borders closing, and those sort of things, I think would have been slightly easier to do.

MR WEATHERBY: Yeah. Thank you very much.

LADY HALLETT: Thank you, Mr Weatherby.

Thank you very much indeed, Mr Hughes. Very grateful to you for the help that you've given in providing the statement and coming along this morning.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Really grateful.

MR KEITH: My Lady, the next witness this morning is Kemi Badenoch.

LADY HALLETT: I have no idea if that's necessary any more, but we do it anyway.

THE WITNESS: Thank you.

MS KEMI BADENOCH (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4

LADY HALLETT: Thank you very much for coming back. Very grateful.

THE WITNESS: Thank you.

MR KEITH: Good morning. Could you start your evidence, please, by giving us your full name.

A. My full name is Kemi Badenoch.

Q. Ms Badenoch, thank you very much for attending today and also for the provision of your witness statement dated 4 July 2024. The Inquiry is, of course, very conscious that you gave evidence -- you've already given evidence in Module 2.

A. Mm-hm.

Q. So thank you for coming back.

During the period with which this module, Module 4, is concerned, Ms Badenoch, the Minister for Women and Equalities was in fact Liz Truss MP.

A. Yes.

Q. But you were Minister for Equalities from 13 February 2020 to July 2022.

A. Mm-hm.

Q. Whilst for one part of that period you were a minister, I think, in the Treasury, and for another part, a minister in the Department for Levelling Up, Housing

and Communities (DLUHC), at the same time there was a Minister for Equalities, Mike Freer MP, I think in the Department for International Trade, Baroness Berridge, a Minister for Women in the Department for Education, Justin Tomlinson MP and then Chloe Smith MP, ministers for Disabled, in the Department of Work and Pensions.

So in the context of a pandemic, and therefore being concerned with the disproportionate impact of a disease on subpopulation groups, and concerned with the take-up and delivery of vaccines, was this ministerial structure rather fragmented?

A. No, I don't think so. But, to explain that, it's probably important to understand the genesis of these roles.

Q. Please.

A. The Government Equalities Office as it started was really created to deliver one policy, which was gay marriage. So this rule was created almost as a policy response, and effectively the Minister for Equality position, when -- and especially when joined with the Minister for Women position, was about delivering specific policies for the government of the day rather than looking at policy across all of government.

And in particular, certainly until I became Minister for Equalities, its sole focus was really looking at

LGBT issues. So the role changed around the time that I started, which was in -- during Covid, and we bought together other departments which we thought could help deliver a more balanced agenda.

I became Minister for Equalities in February 2020. I was actually on maternity leave, so I didn't actually start until April 2020, by which time the pandemic had begun.

But if you look at each of those roles, they are doing something specific. Every government minister, every government department, has to deal with equality. It's not something that one -- that only one minister should be looking at, or only a certain set of ministers. It's like having a risk officer or a risk minister. Everyone should be assessing and managing their own risks; everyone should be following the Public Sector Equality Duty.

So from that perspective it's not fragmented. And the reason why we have an equalities minister in the Lords is because we need someone who can respond to those questions in the Lords, and just help out.

So that was a supporting role rather than evidence of fragmentation.

Q. So you've referred to the Government Equalities Office. Historically, there have been number of offices or units

within government dealing with separate sectorial issues. So there was a Race Disparity Unit?

A. Mm-hm.

Q. A Disability Unit, I think, and a Government Equalities Unit, and all that was brought together in the single Equality Hub --

A. Yes.

Q. -- of which we'll hear more?

A. Yes.

Q. I think -- and is that the bringing together of those disparate elements of which you speak at the beginning of Covid, I think in September 2020?

A. Yes. That was a decision that was made by Liz Truss, and we talked about it and agreed that a hub and spoke model was the best way to deliver across the board. A lot of departments didn't really want to think about equality and would rather someone else just had it so they could just focus on delivering. And you will notice that all of us had roles in other departments, so we were not solely focused on equality.

This is something that has been challenged several times, I remember being asked about this in the Women and Equalities Select Committee. I do think that that model works, and what it means is that it forces a way of thinking in two departments. Being in the Treasury

at the same time as I was Equalities Minister was actually quite helpful because I could use some of the Treasury levers which I would not have had if I'd just been in a totally separate department where they probably would have been less interested in my work, because they were prioritising theirs, and that has meant that the way you need to think about equality, the best practice, lessons learned, ends up being seeded across departments because you have ministers wearing both hats.

Q. So one can readily see the advantage of having a minister concerned with equalities amongst the portfolio for which --

A. Mm.

Q. -- you are -- (overspeaking) -- is concerned with, and the embedding or the embedment of best practice and lessons learned in each department. But by having a number of ministers and not having a single higher-level minister, a Secretary of State, for example, concerned with equalities, did that mean that politically, the whole area of equalities was able to -- well, had less political heft or clout, weight, at the highest level of government?

A. No, I don't think so, and to be honest, a lot of these things end up being determined by the personality of the

person who is in the role. If you have someone who is perhaps more -- "extrovert" is not the right word, but who perhaps has a real passion for these things and is able to make the case and make the argument in government, they will have more salience than perhaps someone who is also interested in it and who just happens to have been given the role.

The political skill of the person who is inhabiting the role makes a difference, but the point you're making about whether this means people aren't focused on equalities across the board is a good one. Looking at it within the pandemic perspective is easier than when there is no pandemic. The roles were not created just for the pandemic; it just happened to be what was there at the time. But equalities covers everything. If you look at the Equality Act across the board protected characteristics, it can be everything from how economic policy affects elderly people or young people, how education policy is affecting, you know, people of a particular religious background. It covers every single thing. And so the political salience often is determined by what is in the news at a particular point in time.

Covid was in the news. The disproportionate impact on ethnic minority communities was in the news, so

equality suddenly took on a lot more work and had a lot more attention. I was in the role at the same time and happened to have very strong views about how things should be done, I happened to have a lot of personal experience, and my own personal bias of wanting to start with evidence and data rather than what often tends to happen in politics, which is noisy campaign groups and lobbying and whoever can get the attention of someone for political campaigns, and that, I think, influenced the approach we took with quarterly reports, for example, bringing in more scientists and thankfully having the RDU, which was a great unit, not a delivery unit, just mainly data focused.

If it had been a different person or a different type of issue, the response would have been quite different, I suspect. So it adapts.

Q. So rather than relying on the interpersonal and political skills of an individual minister as part of this structure, would it not be better to have a single, higher-level government minister responsible, in an overarching way, for the delivery, to use that terrible expression, the delivery of Inequalities and for -- and in particular in the context of a pandemic, dealing with the impact of the pathogenic outbreak, dealing with take-up, dealing with barriers to access and so on?

A. I'm not sure that would have worked. We did have someone in Cabinet with that responsibility. I was a junior minister at the time, but Liz Truss was in Cabinet so that would have been her job. If what you're saying is, should we have had someone who was exclusively focused on that and had nothing else, I think that the disadvantage would be they would have no levers. They would purely be in an advisory role because the secretary --

Q. They wouldn't be in a spending department?

A. No, they wouldn't be in a spending department or a delivery department, they wouldn't have levers. And this is where we need to look at the reality of what government is like, that every department has its own silo with which it's working. It's not that easy to partner up. We do try and collaborate, certainly in my experience, but collaboration often is determined by the interpersonal relationship between two ministers. Otherwise, the usual office politics we find in any organisation come in, where "This our money, it's our business, we know what we're doing, you know, leave us alone," not invented here syndrome.

So I think we need to be realistic about the likelihood of success with that model. What you want is every single Secretary of State or every single

minister, whether they're in cabinet or elsewhere, understanding what it means to deliver properly when it comes to equalities across the board.

Q. All right. Your responsibilities, when you were minister, were extremely wide, were they not? In the context of responding to the pandemic, your ministerial functions included all the usual work done on racial and ethnic disparities. I think you responded for the government to Dr Sewell's Commission on Race and Ethnic Disparities?

A. Yes.

Q. You were dealing with the Gender Recognition Act. You sponsored the Social Mobility Commission. You were concerned with the Equality Act. So all those functions carried on during the course of the pandemic, did they not?

A. Yes, the Commission on Race and Ethnic Disparities actually was as a result of the pandemic. That was -- it was one of the government responses to what we saw as a lack of trust amongst communities across the board, which was highlighted during the pandemic. So --

Q. All right.

A. -- that would not normally have been something that we were doing. The work of the Social Mobility Commission carried on but it was very low priority. It did not

take up that much time, and it is independent, the minister's work is really overseeing and making sure that it's running properly.

So my work, thankfully in the Treasury, was not that -- it was not that intense because almost all of the resources were mobilised towards managing the pandemic. I filled in for other ministers who were busy. So I did have time, certainly in the Treasury, to do the things that you've outlined.

Q. You were responsible for the production and publication of the four quarterly reports --

A. Yes.

Q. -- to which we'll return in a moment. You were obviously concerned with the issue of communications with ethnic minority groups and subpopulation groups and other marginalised groups in society in the course of responding to the pandemic. You were intimately concerned with addressing problems surrounding the uptake of vaccines, dealing with mis- and disinformation. You attended the Covid-O Cabinet committee meetings, and you presumably liaised very closely with the Covid-19 taskforce and other parts of the government concerned in responding to the pandemic.

I just want to look -- I've mentioned the Covid-O Cabinet committee meetings. Can we just have look at

a Covid-O meeting, please, on 25 January 2021.

A. Okay.

Q. INQ000091823. We can see from the top of this page it's the minutes of the Covid-19 Operations Committee. Your name is there towards the bottom of the first page.

A. Yes.

Q. And if we go to page 4, we can see a long section of text from the Minister for Covid Vaccine Deployment. Was that Nadhim Zahawi?

A. Yes, that should have been, I believe, that's right, yes.

Q. And what he says is:

"... although vaccine confidence was running at an all-time high ... the 15% of people who were vaccine hesitant skewed towards Black, Asian and Minority Ethnic communities."

And I know the policy position of the government is we no longer use the acronym BAME, but it was being used then.

A. Mm.

Q. "... further action [was] necessary. Work would continue with the Secretary ... for Housing, Communities and Local Government to minimise issues across hard-to-reach groups ..."

Again, we don't use that phrase nowadays.

"There were concerns with the level of anti-vaccination messaging ... Local community champions ..."

And then further down, "Concluding", he returns to the issue of welcoming colleagues' views on identifying further barriers, safety concerns, lack of access to health services, translation into different languages, and so on. Also a reference to local and trusted voices.

And perhaps just to finish this, if we go over the page, one more page, please, we can see a number of separate points under that general heading in that rubric, particularly data --

A. Mm-hm.

Q. -- and the need to monitor effectiveness.

There was no doubt, was there, on the part of government ministers and the various government bodies, that there were real issues with reducing barriers to access --

A. Mm-hm.

Q. -- increasing confidence in the vaccines, and trying to get vaccines delivered effectively, safely, speedily, to all the many subpopulation groups within our population?

Give us an idea, please, of the degree of will, will-power, the speed with which the government was on

to this issue.
A. Mm.
Q. It's obviously referred here at the highest level, and we'll see in a moment it's referred to in Cabinet?
A. Mm.
Q. But did the government, do you assess, get on top of these issues as quickly and as effectively as it could have done?
A. So specifically on data --
Q. Well, actually all of this, but data is an important part of the topic.
A. So data was the biggest challenge. This might be because the unit that I was overseeing, the Race Disparity Unit, was a data unit, and so we would have been more interested, perhaps, in data than others. But we constantly encountered issues in just finding out what was going on.

Sometimes that was because the data hadn't been collected in the first place so there was nothing to look at, and finding out whether it had or had not been collected could also be a challenge. So you didn't know whether there was something to see and we couldn't find it, or there was nothing to see.

Then there was the issue of people having data, but not wanting to share it because of the conditions that

they had been given when they were collecting it in the first place, GDPR, consent, and so on, and probably a third bucket of there being an issue of trust or not wanting to collaborate with others, people wondering why do you need this data? Don't worry about it. We can do this ourselves. We don't need you to look at it.

So a level of competition, perhaps, or just suspicion about why other groups are carrying out work which perhaps some units may have felt was solely within their purview.

I can't remember specifically where these other bodies were. I know some of it was in academia, a lot of it was in the NHS, just getting information out of the NHS I found was the hardest thing.
Q. Presumably, there are any number of systems within government for the recording and dissemination of data.
A. Mm.
Q. In ONS, there's obviously data there?
A. Mm-hm.
Q. Public Health England, UKHSA, as it then became. NHS England obviously has data. GPs. There were a number of observational studies.
A. Mm.
Q. UK-REACH, OpenSAFELY, which had access to millions of records.

A. Yeah.
Q. So the problem wasn't a shortage of data. Was it -- did the problem lay in its -- did it lie in its production in a useful form to decision makers?
A. There was a shortage of data. Just because there's lots of data, doesn't mean that it's what you're looking for. So in terms of -- if you're talking about volume, yes, there was lots of data. But I remember us trying to find out the ethnicity of people who had been dying, especially the frontline ethnic minority workers in the NHS. We didn't have that. So my first quarterly report I think talked about the mandatory collection of that sort of data. So there were still things missing --
Q. So, at the beginning, there was a specific problem with the recording of ethnicity data amongst patients in hospitals and also amongst --
A. Staff.
Q. -- those who died from Covid?
A. Yes, and it took this a long time to get this resolved. The hoops that needed to be jumped through, I was told -- because I wasn't the one carrying out the data collection, but I was told by my team that it was quite difficult. And I know they eventually got there.

But you are right, across multiple systems, whether it's OpenSAFELY, ONS, and so on, there is data.

Sometimes the data that you have is not necessary -- it's not live; it's old. And the systems are set up to do different things. They don't necessarily use the same categorisation to reference the same information. And that is understandable because these things have cropped up in different ways; they've been set up for different purposes.
Q. We'll move forward and look at, in fact now, your final report, the final -- the fourth quarterly report, dated 1 December. Because there was much in that, wasn't there, about data, and you made number of recommendations about how to better accumulate --
A. Yes.
Q. -- and publish and then rely upon data.

Can we have INQ000089747, please.

This the fine report, dated December 2021.

And if we could pick it up, please, at page 5.

There is an overview and executive summary. This was obviously the fourth report, and so it builds upon the learning and the knowledge which was set out in the earlier reports.
A. Yes.
Q. And this page is concerned with the increase in your understanding, your better understanding of the risk factors involved in the pandemic. At the bottom of the

page:
"The most significant measure to protect ethnic minorities from the risk of COVID-19 infection and to save lives has been the vaccination programme."
Then over the page, page 6.
You set out there how:
"... the government worked with national and local partners to promote vaccine uptake ..."
And there's a number of ways set out.
Thank you very much.
Then if we scroll back out, there's a reference to the Community Champions scheme, in the bottom half of the page, and to wider public health lessons.
And then, I'm afraid, one more page, please.
That part finishes on page 7, and then on page 8 a number of recommendations. They're not numbered, but if we could scroll back out and go down to what is roughly recommendation 11 -- it'll be over the page, I think. Thank you very much.
The top bullet point:
"Relevant health departments and agencies should review and action existing requests for health data, and undertake an independent strategic review of the dissemination of healthcare data and the publication of statistics and analysis."

Ms Badenoch, this fourth report was published in December 2021.

A. Mm-hm.

Q. So the end of 2021, at the end of the second year of the pandemic. You were calling for, and making a recommendation to this effect: for relevant health departments and agencies to review and action existing requests for health data and to carry out a strategic review.
May we take it from the fact you were still calling for this, and you were making a recommendation to this effect at the end of December 2021, that, by that stage, the system was still not working as well as it might?

A. I think this was really a forward look, because there was -- and I can't remember the exact name now, but there was a new office for health disparities that was -- that was to be set up.

Q. Indeed.

A. And I wanted to make sure that it was starting with the knowledge which we had accrued and starting with some of those actions, and actually able to monitor them. So the Equality Hub, doing this work, was always a time-limited thing. We certainly did not have the resources to monitor what every department was doing throughout. So this was a discrete project, a discrete

piece of work. We've carried out recommendations. But I'm -- at this point I'm thinking: well, we're going to have to go back to our day-to-day, how do we make sure that this work carries on and people understand the lessons learnt?
So the hope was that new office for health disparities -- I'm sorry, I genuinely can't remember the name of it now, but I know that it is in existence -- would be picking up this sort of work and running with it.

Q. As it happened, the government commissioned a report into health data, it's called the health data review, and it was led by Professor Cathie Sudlow.

A. Mm.

Q. It reported in November of last year, 2024. I wanted to ask you, and I appreciate it's not something that you've been required to look at, but I wanted your impression.

A. Mm.

Q. Amongst the five recommendations that Professor Sudlow made were these two recommendations: that there should be a national health data service in England for health data; and secondly, that there should be a UK-wide approach to streamline data and, therefore, to better -- well, to improve understanding by all the governments within the four nations of the impact of the data and

what can be learned from it.
Are those two recommendations something that you would endorse? Was it your view that something did need to be done about setting up a national data service and having a consistent aggregated approach across the United Kingdom?

A. Yes, with caveats. So yes, I do think some streamlining and rationalisation of data sources is necessary, and also making sure that we're using the very best labels, the very best categorisation, because it is confusing. You know, you talked about the use of the term "BAME" -- there was so -- there's a plethora of labels that was being used. We never knew whether we were all talking about the same thing or not.
So yes, in principle, I do think that that is something that should be done. I don't know the genesis of Professor Sudlow's work, but I have come to this conclusion via separate avenues.
However, there is a challenge now with how well government itself is placed to deliver this sort of system. And I remember, it's over 20 years ago now, when I was working on a project for the NHS Spine, when we were supposed to have a National Health Service, you know, IT system, and it failed. Government is not necessarily great at delivering these systems. They

tend to be big boondoggles for the private sector, but there are private sector companies that can deliver this. There need to be caveats around that. There is a big debate going on about how we use health data. Should we let AI into the system? Because the more data you have, the harder it is to process, and you start to require machine learning and so on. And there are many ethical concerns about allowing this data to be used by pharmaceutical for profit sectors and so on.

I personally have no issues with that, but those things need to be considered in tandem if we are going to do this.

There are a lot of risks as well, which I've seen from being in government, having security briefings about how external actors outside our country try to destabilise information systems. There would be a big risk in creating something like this. It's important that we are aware of those and have things to mitigate, but in principle, I think that this could work.

How we deliver it would be the question, and make sure it could be quick and successful.

Q. The Equality Hub, for which you were responsible, produced a report in July and August -- in August 2021 called Perceptions of the Pandemic research.

A. Mm.

Q. Which showed high levels of distrust in the population that there was significant numbers of people who didn't care about the pandemic, didn't have a great deal of trust in government --

A. Mm.

Q. -- and believed that they should not take up the offer of vaccination.

A. Sorry, what date was this? I'm trying to make sure I'm not --

Q. It's August 2021. It's called Perceptions of the Pandemic and it was research carried out by the Equality Hub.

It's obvious that your quarterly reports made a number of serious and considered recommendations. Your first report made 13 recommendations. There were a number of recommendations in the second report. And then in the final report I think there were as many as 17 recommendations.

The fact that the reports worked on and then published, over a considerable amount of time, from 1 February 2021 to the end of 2021, rather suggests that the government was having difficulty getting traction in getting change brought about. Would you agree?

A. Yes, it was difficult, but also, it was novel. We were doing things that we hadn't done before. And I think

that can make things slower.

Resources were also limited, not just in terms of, you know, people who knew how to do this, bodies on the ground, but also everybody was dealing with the impact of Covid as well. We weren't all in the same place. The sort of things that might happen faster if you're working in the same room, people just being in the same home, people falling ill, getting Covid themselves, family impact, all of that just ended up slowing things down.

Q. In your statement and perhaps we could have it up on the screen, please, INQ000492283, at page 16, you set out a number of the initiatives which your department or which the Equality Hub put into place: the setting up of vaccination centres in around 50 places of worship, bespoke programmes to increase vaccine confidence in particular communities, targeting religious events, the use of pop-ups, improving uptake amongst ethnic minority healthcare professionals, working with the BBC Asian Network World Service. I could go on. A long list of things that were done.

A. Mm.

Q. By and large, were you successful in driving up uptake as a result of the many initiatives which were undertaken?

A. I think it made a difference. It certainly created improvements. The biggest benefit, I think, was the awareness raising which meant that other people started doing these things, and we weren't relying just on government.

Government alone cannot deliver at this scale. You do need the rest of, you know, whether it's civil society and just people using their own initiative. And I think that was the biggest difference that it made.

I wouldn't say, for example, that we were able to personally touch every single ethnic minority in the country, or that every single person heard every single bit of government messaging, but the dissemination and the spread and the concepts -- I remember we had, you know, certain phrases that we needed to seed, I think those did get embedded.

Some of the things were not as -- were not as effective. I remember trying to use the high commissions to target the diaspora groups. I never really saw any evidence that that worked. They did try but I don't think that, going forwards, that would have been a place that I would really spend much of an effort, we were -- (overspeaking) --

Q. Just expand on --

A. -- (overspeaking) -- hoping --

Q. Expand on that, if you would be so kind. You spoke, I think, to, or met with number of high commissioners?
A. Mm.
Q. What, from those countries whose nationals were most at risk from Covid?
A. Yes, or certainly people from that ethnic origin. And what I found was that they also could not reach the groups that we struggled to reach. So they didn't have a much better access. They tended to deal with people who were, you know, using consular services and so on. They were not the hard-to-reach groups. The hardest-to-reach groups, if I recall, were people who were dealing with perhaps a home country via personal or private channels, not through the High Commission. So they didn't interact with it. They didn't need it for passport services. They just didn't know who those people were either.
Q. All right.
It's obvious from your statement, that there's a distinct limit on what central government can do.
A. Mm.
Q. You can identify the problems, you can convene meetings of people to discuss what can be done to solve those problems, and you can generically approve plans, actions and identify broadly what needs to be done.

A. Mm.
Q. But there are a great deal of departments and entities and bodies concerned in this field from directors of public health, local authorities, NHS England, the JCVI, and SAGE had a role as well.
A. Mm-mm.
Q. The DHSC, and the Office of the Chief Medical Officer. So there is a very significant number of bodies trying to deliver, to use again that terrible expression, but trying to deliver what it was central government wished them to do. Is there a way of operating this system in a more efficient way, or at least of being able to understand more clearly who is actually going to be accountable for delivery, who is going to be responsible for practical measures on the ground, or does it have to be this way?
A. Honestly, I'm not sure. Because when you look at some of the things that needed to be delivered, it had to be local government. There's no way that central government could do those things. You need local councils, whether it's counties or districts, who actually know and understand the communities. So I think trying to drive everything centrally will not work, and so that's why I'm probably not convinced by the idea that we should just have a big central hub that

knows everything and knows what it's doing.
I often say that we need better government, not more government. The more different bodies that exist, the harder it is to actually know who should be doing what. So there is an argument for having some streamlining. But each of those bodies, you know, JCVI, for example, was tasked with doing something specific and they should have been collaborating. So better collaboration across the board is important.
There will often be some duplication, but with -- I mean, the list we were looking at. Some of this was trial and error: we think this might work, let's do it anyway, it's better to do it than not do it. The feedback mechanisms for what actually works are very weak indeed. It's very hard to know what is working and what isn't. It certainly felt like that during the pandemic.
Q. What is working on the ground?
A. Yes, and so there is a try everything, because some of these things will work, and it's better for us to duplicate than to miss something. And I think that was the -- that was the attitude that we took. So that's why the list was so long. Not everything would have been effective but -- I could see some areas that certainly were not effective, and others where we knew

it was working but exactly how or why, it was just really difficult to get a good feedback.
MR KEITH: My Lady, is that a convenient moment?
LADY HALLETT: Certainly.
I'm sorry we have to break, Ms Badenoch, but I promise you, you will finish your evidence before lunch so you can return to other duties.
THE WITNESS: Thank you.
LADY HALLETT: I shall return at 12.05.
(11.50 am)
(A short break)
(12.05 pm)
LADY HALLETT: Mr Keith.
MR KEITH: Ms Badenoch, I was asking you about your meetings with high commissioners.
A. Yes.
Q. Just been asked to raise a particular point in connection with that issue. You said that the meetings weren't terribly effective, not because there was a lack of will, perhaps, or willingness to assist, but perhaps because it didn't lead to a visible improvement in the position in terms of the diaspora from each of those countries taking up the offer of vaccination, which I think was the point of the meetings?
A. Yes, and also because I think we were asking them to do

something that they had not done before either. They weren't set up to do.

Q. Was another issue, or another problem, that there are a number of people, perhaps asylum seekers, who won't be in contact with their high commissioner, or perhaps if they're illegal immigrants or asylum seekers, they're not permitted to be in touch with their high commissioners, and therefore there was a limit with what the high commissioners could do, in terms of reaching out to their populations?

A. No, I think it is more fundamental than that. Yes, it is true those groups would not be in touch with a high commission. If you're seeking asylum from a place, you wouldn't go to that -- you wouldn't be in touch with the embassy or the high commission of that place.

Q. Yes.

A. But those cohorts, certainly asylum seekers, refugees, would have other interactions in the public health space and they would have other points of contact.

With illegal immigrants, this is a more fundamental question. These are people who are not in the country legally. Then -- so effectively committing a crime even by being here. Their interactions with the state will be minimal to none, because they will be worried about being --

Q. Reported?

A. Well, being deported, and that is just one of the -- you know, that's just a fact. We cannot adjust our health system, in my view, to undermine borders and border security. That would create loads of other problems. So that's just something that I think we need to accept.

Q. All right.

A. But the real reason why it wasn't effective was because high commissions aren't really set up for that sort of public information. It's just not what they do.

Q. You spent a great deal of time holding roundtables with ethnic minority healthcare professionals, professionals across the healthcare sector, I think the Chief Midwifery Officer, and of course with the NHS, NHS England. Did you liaise much with the National Pharmacy Association, and in particular, address the issue of whether or not community pharmacies could offer more by way of vaccination sites?

A. Yes. I remember one meeting with pharmacies -- I can't remember whether it was the National Pharmacy Association or another body that was representing pharmacists and community pharmacies as a whole, but this was one of several groups that I remember having roundtables with to find out how they could help, and they specifically said they wanted to do more.

And I remember we used a particularly well known pharmacist to channel one of our communication projects. I can't remember -- I can't remember her name, but we wanted to get community pharmacies more involved. They thought there was more that they could do and I think we did successfully utilise them to deliver the vaccination programme. It was very much all hands on deck.

Q. Can we have INQ000477623, please.

This is an agenda for a National Pharmacy Association meeting with you, and Nadhim Zahawi, the Minister for Covid Vaccine Deployment, on 7 January 2021.

A. Mm.

Q. The attendees, and in particular the representatives of the National Pharmacy Association, make the point very strongly indeed that there is a very wide network of pharmacies across the United Kingdom, 14,000 in all, that they are a diverse profession, and then -- over the page -- you can see references to how:

"Community pharmacists have a trusted relationship with patients ... [they're] well placed to dispel myths ..."

They have a great deal of regular face-to-face contact with the public and I think it was well known that pharmacies tend to operate in areas of greater

deprivation, and they're particularly good, of course, at delivering medicines to those who want to walk from local areas to the pharmacies.

It doesn't appear, Ms Badenoch, that the pharmacies were used perhaps to the full extent that they might have been, in particular because they don't always open, I think, the 12 hours a day that they were required to do under vaccination arrangements, and also the system obligated vaccination sites to get through and deliver a certain number per week, which many small pharmacies just couldn't do.

So do you think more might have been able to have been done in terms of using pharmacies in the local community to get vaccines offered and delivered?

A. Well, I wouldn't know, because -- I mean, this is an agenda for a meeting. These aren't the minutes. Just looking at the structure. This is an agenda for the meeting, so this discussion was had, and at the end of it there would have been a recommendation.

I recollect community pharmacies being used, but the conditions would never have been determined by my unit, and I would not have been aware of the success in terms of deployment of vaccines.

My understanding was that they did do that, but it may have been only those that opened for the full

12 hours. And I don't know what the reasons for that --
Q. All right.
A. -- I don't know what the reasons for that were.
Q. From the paperwork produced by your department, it's also obvious that there were a great deal of, many meetings with local authority leaders --
A. Mm-hm.
Q. -- and time spent debating how local authorities could step into the breach and ensure that public health messages were disseminated and that members of the local populations would take up the offer of a vaccine. By and large, do you think that local authorities were used enough? It is obvious that in any system of national vaccination, that it has to be driven by the centre, and obviously questions of prioritisation and manufacture and delivery have to be driven by central government.
A. Mm.
Q. Do you think local government played or was asked to play a sufficiently important role?
A. I think so. I wasn't in DLUHC during the height of this. By the time I came into that department, a lot of this work had been done and it wasn't, strictly speaking, within my policy area. But I do recall multiple meetings being had with leaders of local authorities. I think that what you've described is

really more appropriate for directors of public health who work in conjunction with local authorities, the integrated care boards.

Local councils have a very specific remit when it comes to health delivery, and I think that this would be, you know, giving them more to do would be quite a challenge. It's not what they're used to doing. I think it's the directors of public health and using the health mechanisms locally, rather than the local authorities specifically.

Q. But aren't they the bodies who are most likely to know what the state of deprivation is locally, the degree to which vaccines were not being taken up by ethnic communities, and also what, practically, on the ground, could be done in terms of going door to door, to housebound residents and making sure --
A. Yes.
Q. -- that they were vaccinated? Isn't that a local authority issue?
A. It is, but that, I think, they did well. I mean, I saw what my local authority did, and I thought that they did that fairly well. But in terms of the more clinical public health aspects, I would expect the advice to be coming from the Director of Public Health, the delivery levers perhaps using local authorities. But from my

understanding and my own personal experience, I thought that was what they were doing.
Q. How effective was the Community Champions scheme, which was something very much at the heart of your department's response?
A. Actually, Community Champions was a DLUHC-sponsored scheme. We advised, and they were already carrying out a Community Champions scheme. We advised on how it could be used to deliver the objectives of the work that we were doing. So we worked in partnership with them, but it was actually Levelling Up, Housing and Communities' responsibility, the Communities department led on Community Champions and we fed in. And we gave them a lot of insight and a lot of intelligence on where to go, I think, and how to make sure that it was successful. But the delivery of it was actually in DLUHC. And I think that they did do a good job. It wasn't everywhere.

So Community Champions was specifically in those places where we thought people were hard to reach, and my understanding and the reports which we got back, which I don't have to hand, but I had a better feedback mechanism from what Community Champions were doing than I did on the communication angle, where we just weren't sure what was working and what wasn't.

Q. And what is the great value of a Community Champion? Is it to do with being able to provide for a high-profile, trusted local figure whose messages about vaccination will be believed and accepted and could raise the profile, of course, of -- in public health terms, of what the government is seeking to do?
A. Yes, that, but also they know what's going on in a way that those of us with offices in Whitehall will never know what's happening in a particular local community.

They have a better understanding, better intelligence, and they are part of those communities, so they want them to be, you know, healthy and successful. They have a vested interest in seeing things work.
Q. Mis- and disinformation. Your fourth quarterly report made a number of recommendations concerning trying to -- or what could be done to dispel myths, reduce fear and build confidence amongst ethnic minority people. Was the further work that you identified -- and it was in your first quarterly report of October 2020 -- was that further work done, do you know?
A. No, I don't know how far the work was taken. I know that there is, or certainly there was, a unit that looked at this, but they looked at misinformation and disinformation across the board, and a lot of its work is very sensitive.

Q. Can we have a look at INQ000089742. This is Ms Badenoch's statement -- no, I think it's the first quarterly report and page 62.

No, I think I must have the page reference wrong there.

We'll try one more. Can we have INQ0000897 -- no, I think we'll leave it there.

Two pages of the first quarterly report set out, in quite significant detail, the degree of prevalence of misinformation and disinformation.

A. Mm.

Q. In terms of countering dis- and misinformation amongst ethnic minority groups, is there a limit on what central government can do?

A. There's always a limit on what central government can do. I think it's probably worth explaining what it is that I mean by misinformation and disinformation. People often assume that it's, you know, stuff on Twitter or X. I'm actually less worried about that sort of misinformation because it's very public and people who know can challenge it easily. So that's an open sphere.

The things that really concern me are the pieces of information that are less visible. The last time I was here I talked about WhatsApp groups, for example, family

WhatsApp groups, things that government has no insight into. Even the tech companies don't really know what's being shared, it's all encrypted, and a lot of false information travels very quickly through those channels and I don't know how we can deal with that. And it's everything from "vaccines will kill you" to "the government is suppressing information". In fact, some of it often has, you know, likely reputable sources who are backing it up.

I remember we had some people from the BMA who genuinely believed that we were trying to stop information from getting out about what was happening with the ethnic minorities. And when you see that on a public forum you'll think, "Oh well, well if the doctors in the BMA think that, then it must be true", but even they were wrong and then that starts to propagate. And the thing that government can do best is provide as much information as possible and show that we are, you know, that we're all in it together.

That was one of the reasons why I decided to take part in vaccine trials, that if people thought that the government was trying to kill them, then if the minister herself was taking part in trials which are more risky than a fully-tested vaccine, that might help with public trust.

But I don't know the answer to dealing with that sort of back channel information that's peer-to-peer and private beyond the government supplying as much honesty and as much truth as possible. And also not attacking the people who are propagating these. So as annoyed as I was by, you know, representatives of the British Medical Association saying these things, what I didn't do was go after them, because that can actually fuel the misinformation or the conspiracy.

Q. All right.

In your final quarterly report you made seven recommendations, all of which, I think, were accepted by the then Prime Minister in full; is that right?

A. (No audible answer).

Q. And I just want to focus on a handful of them.

Recommendation 6, and you've just referred to the issue of clinical trials, recommended that confidence be built in future vaccination schemes by increasing ethnic minority participation in clinical trials.

A. Mm.

Q. Was it your view, at the time of the promulgation of the report that there had been insufficient diversity in clinical trials? We've had a great deal of information and evidence about the actual figures for diversity in the clinical trials on the part of all three of the

Covid-19 UK vaccines. But was it your view that certainly in the public sphere, there was a lack of confidence in vaccination, in part contributed to by a belief -- rightly or wrongly -- that there was a lack of diversity?

A. No, I think it's -- there's a lot of "yes" and "no" in that. I think it's more complex. So let me try and unpack this. Within ethnic minority communities, irrespective of what's happening here, there is distrust of public authority. Most ethnic minorities have come from authoritarian regimes or places where the government may actually be trying to get you, and that's why they've come here. So there is a baseline level of suspicion that is just higher than we in the UK have generally, and it builds from that.

So when we're looking at the lack of trust, we've got to have that in mind, that there is a cultural aspect here that shouldn't be ignored.

Do I think that it is true that ethnic minorities did not participate in vaccine trials? Yes. First of all, for that reason. Secondly, just because it just wouldn't have been -- it's just harder if you are in a community that's more likely to be closed, if levels of education are lower, it's not something that you would ordinarily do. I think that that's right, but

that's just personal observation.
I did have clinical representatives tell me that participation was low. And if they said that, there was no reason for me to dispute that. Anecdotally, I would have expected that and --
Q. And that's why --
A. Yes.
Q. -- you said that in your recommendation that participation should be increased?
A. Yes.
Q. We've discussed data already but I think four or five of the recommendations in the final quarterly report were about data and they reflect what you've said this morning about your concerns about the operation of the data systems. Did you happen to have in mind or did you make any recommendations concerning recommendations the recording of data for disabled people or was that outside the brief of your report?
A. It was outside my brief but I think it was discussed. I can't recollect where, where there were issues or if there were issues. But we had to draw a boundary between what I was doing versus what Justin Tomlinson as Minister for Disabled People was doing. We had a team in the Equality Hub that collaborated and worked together but there was only so much that I could look at

that and that was, strictly speaking, outside the remit that I'd been given.
Q. Right.
Recommendation 17 suggested that the government needed to build on community partnerships and work closely with local networks to improve understanding and gain insight into the audience -- the audience being ethnic minority groups -- for the purposes of future public health campaigns --
A. Mm.
Q. -- and that government needed to utilise community partners to co-create content and tailor communications that resonate better.
Ms Badenoch, it's obvious that you had a great deal of communication with trusted figures --
A. Mm.
Q. -- local trusted voices, local authorities, all manner of representative bodies and groups, as well as other parts of government. So what did you mean, in practice, when you said that community partnerships needed to be built on and there needed to a closer working relationship? Were there not already all number of meetings and any manner of emails, roundtables, communication with everybody working in local government and also in the voluntary and charitable sector?

A. Yes, but that was all in the context of the pandemic. And as we were coming out of the pandemic, many of those bodies would not be convened again. So it was about leaving a system in place, not as intense as what we had right, you know, in the middle of 2021, but something which could be mobilised more quickly should this sort of thing ever happen again, and actually, learning some of the -- you know, there were many insights that were gained that were adjacent to the work that we were doing on Covid-19, and seeing that level of collaboration just producing useful information I thought was something worthy of pursuing. But it had to be -- it still has to be encouraged but organic. Central direction I think will just end up with lots of people having meetings and not really doing anything serious, and then convincing themselves that because they've had the meetings, good work has been done. We need to make sure that with these partnerships it's genuinely outcomes, not just, you know, being in a room and having a discussion.
Q. So at the heart of it, the relationships need to be fostered and they need to be nurtured and they need to be done so outside the particular demands of a pandemic?
A. Yes.
Q. Because only when the next pandemic comes will those relationships work, if they've been looked after in the

meantime?
A. Absolutely.
Q. Like you were saying.
And more generally, those relationships need to be nurtured and pursued, not just in the narrower context of vaccination and the impact of a pathogenic outbreak --
A. Yes.
Q. -- but generally, so that they're ready to go --
A. Yes. And not just top-down but also bottom-up as well, which is -- which I know is harder but it tends to be more long lasting.
MR KEITH: All right. Thank you very much indeed.
LADY HALLETT: Thank you, Mr Keith.
There are just a few more questions for you, Ms Badenoch.
Mr Thomas, who's over there, will start. Thank you.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good morning, Ms Badenoch, can you hear me?
A. Yes, I can.
Q. I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations, and I've only got a small number of questions for you.
A. Okay.

Q. Vaccine as a condition of deployment. Can I just turn to that area, please. In your statement you express very real concerns about the VCOD policy, particularly its workforce implications and the disproportionate impact that it had on ethnic minorities. Do you believe your concerns were taken seriously and sufficiently addressed in the development of this policy?

A. Yes, yes, I do. They were taken seriously.

I recall, having read the briefing notes, the meeting we had, to some extent, where the concerns that I raised were acknowledged, but there were many different arguments in the room about the levels of risk on carrying out the policy and not carrying out the policy, but I never felt that I was being ignored or not taken seriously.

Q. What feedback, if any, did you receive when raising your concerns within the Covid-O Committee?

A. I recall a discussion on the pros and cons of vaccination as a condition of deployment. I had had meetings with the -- I think the BAME Communities Advisory Group, where they were concerned about people leaving the workforce rather than taking a vaccine. And that would have been quite damaging for the social care settings in particular, because we needed those people to carry out the work, but there was also a concern that

if people were not vaccinated, then they would be at more risk of the -- of getting Covid and also passing it to very vulnerable groups. So it was about balancing those two very serious risks and working out what the best outcome would be.

Q. I want to be future looking. Given the policy went ahead for health and social care workers, despite the objections that you raised, are any changes necessary to ensure that concerns of the Minister for Equality are taken in account in the future?

A. Well, they were taken into account. And I think this is just one of the things that we have to accept, that given the government decision-making process, different people will make different arguments. And some people will win and some will not. And that depends on the particular subject. A secretary of state or a prime minister will hear all the competing views, and then make a decision. And I think, if your view is not the one that's taken, it doesn't mean that it hasn't been considered; because they can't agree with everybody.

I think that the fact that the policy eventually didn't go through, or was reversed, and the larger issues around certification in the end were not pursued via legislation shows that it was just not going to be

that workable.

But even I understood the arguments that others were making about why such a policy would be necessary. I didn't agree on balance that we were in the right place. I also, even with the BAME Communities Advisory Group, didn't want us to overplay the significance of the risk there.

PROFESSOR THOMAS: Madam, thank you very much.

LADY HALLETT: Thank you very much, Mr Thomas.

Mr Jacobs.

I don't know if you can see Mr Jacobs.

THE WITNESS: Yes, I can.

LADY HALLETT: Behind the pillar, yes.

Questions from MR JACOBS

MR JACOBS: Ms Badenoch, good afternoon.

A. Hello, good afternoon.

Q. I represent --

LADY HALLETT: Are you switched on, Mr Jacobs? I'm sorry.

MR JACOBS: Can you hear me?

LADY HALLETT: Yes, I can now.

MR JACOBS: I represent Roma, Gypsies and Travellers, and act for the Traveller Movement, instructed by Howe+Co. I wanted to ask you a couple of questions in relation to your statement.

You cite in your evidence a number of initiatives

that were taken to increase vaccine confidence in minority communities.

A. Mm-mm.

Q. I think you discussed these with Mr Keith KC this morning, and some of these initiatives included bespoke programming to increase vaccine confidence and the use of mobile and community pop-ups; is that right?

A. Yes.

Q. And the Traveller Movement's position is that there were no such initiatives designed for the GRT community, the Gypsy, Roma, Traveller community.

A. Mm.

Q. Do you agree, Ms Badenoch, that there were actually no GRT-targeted initiatives, such as pop-up clinics or bespoke community engagement, in respect of Travellers?

A. Well, I know that the department for communities and local government certainly designed the programme with the Gypsy, Roma and Traveller community in mind. And we had data that came back and -- explaining what was going on, and what was taking place.

So my understanding is that there were activities. I also know that of all of the groups that we were trying to reach, that was the most difficult group.

So that might -- it might be more of a factor related to that than that no work was done.

Q. Are you able to say why you consider that was the most difficult group, Ms Badenoch?
A. If I was, it would be from my experience, not as a minister but as a constituency MP who does have Gypsy, Roma, Traveller communities. There is a significant level of hostility to any state body, even on the education side -- visiting as a constituency MP, I didn't feel particularly welcome, even though outreach was taking place, and I think that there are many dynamics within GRT, as we've referred to it in government, that make the sort of response we can deliver in a pandemic very, very difficult, especially at short notice.

You need people who spend a lot of time, probably of that community, who can do this. And if the culture within the community is one that is to not interact with the state it just creates a tension that's very, very difficult to overcome.
Q. Thank you. I have one final question for you. You discussed Community Champions earlier on in your evidence.
A. Mm.
Q. And you say in your statement that the Community Champions scheme allocated £23.75 million in funding 60 councils, and was designed to expand work to support

those most at risk from Covid-19, and boost vaccine take-up. That's right, isn't it?
A. Yes.
Q. And Yvonne MacNamara, who is the CEO of the Traveller Movement, she gave evidence on 16 January, and she said that there's been a historic problem that the GRT Traveller ethnicity is not recorded by institutions.
A. Is not, sorry?
Q. Is not recorded by institutions.
A. Recorded.
Q. And the example that she'd gave is that the GRT are not recorded in the NHS Data Dictionary. Now, we've been looking at the final quarterly report, and I know that it makes that point, doesn't it?
A. Mm.
Q. As a consequence of this lack of recording in relation to data, Ms MacNamara said that local authorities just didn't know how many Travellers lived in their areas because of this data capture issue.
A. Mm.
Q. My question is: do you think, Ms Badenoch, that the Community Champions scheme was actually unable to boost vaccine take-up by Travellers because of this inadequate data capture issue, particularly in England, meaning that GRT people were not sufficiently visible to local

communities?
A. I would be surprised if the level of knowledge in local authorities was that low, purely because, from the experience I have seen over the last 10 years, local authorities know exactly where Traveller communities are because everyone around tends to complain and not want them there. They are very, very knowledgeable about where the communities are. How to get into them is trickier, but I am not sure that, you know, just to the question you're asking about data collection --
Q. Yes.
A. -- I'm not sure that Community Champions was reliant on data in that way. The purpose of Community Champions was that they had the local knowledge, you know, in their heads, almost, and it shouldn't -- if we had had all the data we wouldn't have needed the Community Champions, so I'm not sure that that's how we would have resolved that particular issue.
MR JACOBS: Okay, I don't think I have any more questions for. I'll just ask. No, I don't. Thank you very much.
THE WITNESS: Thank you.
LADY HALLETT: Thank you very much, Mr Jacobs.

Thank you very much indeed, Ms Badenoch. I know how much a burden it must be when we keep asking you to come back.

THE WITNESS: It sounds like you were inviting me again.
LADY HALLETT: Well, I can't make any promises but I do promise -- I can't make any promises we won't ask you back, but I do promise that we'll do our very best to limit any burden upon you. So thank you very much for your help so far.
THE WITNESS: Thank you. I'm very grateful for that; thank you so much.
LADY HALLETT: Thank you.

(The witness withdrew)

MR KEITH: My Lady, that concludes this morning's evidence.
LADY HALLETT: Thank you. I shall return at 1.40.
(12.37 pm)

(The Short Adjournment)

(1.40 pm)
LADY HALLETT: Ms Stephenson.
MS STEPHENSON: My Lady, the next witness is Nadhim Zahawi. Please can the witness be sworn.

MR NADHIM ZAHAWI (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I hope we haven't kept you waiting and you were warned that you wouldn't be on until this afternoon.
THE WITNESS: Not at all, we've got 20 minutes early. I thought I was going to come in at 2.

MS STEPHENSON: Mr Zahawi, thank you for attending to assist the Inquiry.

Just some preliminary matters, you have assisted the Inquiry with a witness statement, dated 22 August 2024, INQ000474307. It runs to 77 pages, 175 exhibits, signed by you.

Can you confirm that you have read it recently and that its contents are true?

A. I have. I've read it, and it's true.

Q. Thank you.

Just touching briefly on your professional background. You became an MP, is it right, in 2010, having qualified as a chemical engineer and having had a career in business.

You held positions as Parliamentary Under-Secretary of State at the Department for Education, and the Department for Business, Energy & Industrial Strategy (BEIS). And of most relevance to your evidence today, between 28 November 2020 to 15 September 2021, you were Minister for Covid-19 Vaccine Deployment. Of course, you later went on to hold roles as the Secretary of State for Education and the Chancellor.

You were Minister for Covid-19 Vaccine Deployment alongside the role of Parliamentary Under-Secretary of State at BEIS. But was it the case that in that period,

the November 2020 to September 2021 period, most of your BEIS responsibilities were handed over and your focus was the vaccine deployment programme?

A. That's right.

Q. Plainly, the UK Covid-19 vaccination programme was unprecedented in the scale and the speed of its coverage. But you are giving evidence today to help the Inquiry understand the process by which that vaccine deployment was managed, and to assist with a small number of issues focusing on how lessons might be learned from those things that were done well, and what might be improved upon as we look forwards.

So I just want to first ask you, before we move on to those discrete issues, about the role as Minister for Covid-19 Vaccine Deployment.

It was a role created with your appointment, was it not?

A. That's correct.

Q. And was it a role held jointly between BEIS and DHSC?

A. Yes, that's correct.

Q. At the time of your appointment, on 28 November, the focus had, of course, shifted to how vaccines would be deployed. Their authorisation was imminent. What was your role in terms of deployment of acting as an interface between the various bodies involved and in

respect of oversight, please?

A. Yes, indeed, and thank you very much, and can I just begin by thanking everyone who is involved in the Inquiry. Of course there are many unsung heroes, civil servants, my own team as well, and I hope we'll get to the teams that made the vaccine deployment a success, the success that I believe it was, and the lessons we'll take away from it, I hope, through the Inquiry.

So my role -- and this bit was probably a little bit of luck rather than design, but because I was in BEIS and a friend of the first VTF lead, Kate Bingham, I was able to see firsthand because -- she was bouncing stuff off me, informally, most evenings, in terms of the work that the VTF had begun doing in identifying the teams that we would then contract with to deliver the vaccines, so the supply side of the vaccine. So I had already familiarity with that.

But this new role, that the Prime Minister, actually, rang to say, "I want you to do this job, you'll work with Matt Hancock, but of course you will lead the vaccine deployment side", was very much around once we receive a vaccine, if we receive a vaccine -- because we didn't really know quite, you know, what the timeline will be as yet, when I was first appointed,

we're getting close but not quite there yet -- it's to make sure that we kick the tyres on how we're going to build an infrastructure to put jabs in arms.

And so within minutes, hours, of being announced, I was on my way to meet Emily Lawson at the NHS to really go through what she'd been working on, and designing with her team with -- you know, what was then Brigadier Phil Prosser, who was embedded into NHS HQ, and a number of other stakeholders, which we can obviously talk about today.

And it became obvious to me that, you know, an enormous amount of work had taken place to get ready for the first deliveries of vaccines, and a deployment strategy was pretty much in place. And I really saw my role as being the sort of -- the connection between the NHS, but then of course the centre, which is Number 10, and the Cabinet Office, and the Department of Health, and the department where the VTF initially sat, which was BEIS, my old department. And that was pretty much my, sort of, day job: to make sure that if there is anything that we needed to iron out, then we could do it quickly, because there was one point of contact.

And I said to the Prime Minister at the time when he offered me the role that I would, of course, step up and take on the role, but I had one condition that I asked

him that he needed to promise, which is that I could speak with his authority, which meant that I had access to him within minutes, hours, rather than days or weeks. And I think that made a huge difference to the ability to help the whole team be able to deliver what I think was the most successful vaccination programme that we've seen in Europe, if not in the world.

Q. What was the division of responsibility between you and the Secretary of State for Health and Social Care when it came to deployment?

A. So obviously the Secretary of State had many other responsibilities to cover in terms of pandemic response, and we reported in to the Secretary of State, but my responsibility was very much the sort of day-to-day operational support that I would offer to both Maddy McTernan, on the VTF site, because she was the lead SRO on the -- Senior Responsible Officer, as we call them in the Civil Service, on the VTF Vaccine Taskforce, and then Emily Lawson as the lead SRO on the vaccine deployment, leading the -- what is obviously the NHS effort to make sure we get the nation protected as quickly as possible.

Q. You describe Dame Emily Lawson in your statement as very experienced and certainly capable of managing the rollout of the vaccine within the NHS in her role as the

SRO in NHS England for vaccine deployment.

Can we take from what you're saying about the point at which you entered your position, that you weren't involved in the operational decisions, the minutiae of the operational decisions about, for example, which venues would initially be selected for vaccine delivery?

Was it -- you're nodding your head, and just for the benefit of the stenographers --

A. Yes, so all that work was done by Emily in her leadership position and her, you know, phenomenal team that, you know, had a pretty detailed plan of the moment we got -- when we hoped we'd get the news then, because we still weren't certain that we're going to get the first vaccine coming through which will get through the various, you know, the various approvals that it required, and then into, you know, jabs in arms. And that work was in place.

What I did do -- and credit to Emily, she took me through it, she said, you know, "Look, you know, kick the tyres wherever you think we might be able to do it better." So we went through it in detail and I could see that, and I had the confidence in the team that they've done, you know, really the majority of the heavy lifting and therefore my role was almost to sort of protect them because what was happening is Emily was

being, you know, pulled into the centre to explain over and over, you know, will this system work? Why is she confident? Have we looked at this? Both to the Cabinet Office and to Number 10. And when I sort of went through, you know, with her, the number of meetings she was having to attend literally just to reassure people, rather than to be focused on the operational delivery, because, you know, there were lots of moving parts in something as complex as setting up, you know, from a standing start, you know, a vaccine infrastructure that she'd put together.

Q. So was it then, perhaps, a strength of the system that might be retained for the future that that you, as Minister for Vaccine Deployment and, indeed, the Secretary of State, did not manage day-to-day what Dame Emily Lawson was doing? She had a good degree of operational independence and was also protected from that interface, as you've explained it, with other departments and with central government?

A. Very much so. And, actually, because it's, you know, the other way round: ie, you know, the danger was too many people who were just simply sort of, dare I say, fretting, who needed to just leave us alone, let the team concentrate on what -- because there was lots of -- you know, in any plan, you know, there are moving parts

all the time because there are sort of delivery points, right, that are dependent on, you know, other action points that needed to take place. And I very much felt that, you know, the best use of the time of the professionals is to get them to focus on that rather than being dragged in to do another presentation as to why, you know, they've maximised every possible avenue to get jabs in arms to protect the nation.

Q. Moving on, then, just to deal with, in summary, the co-ordination with the devolved administrations from your perspective. The vaccine delivery plan, which we'll come to in a moment, describes all four nations as taking a joint approach to securing vaccines. Of course, deployment was a devolved issue, but in the event, all nations followed the JCVI prioritisation advice with little deviation, and was it your understanding, that whilst delivery models might have differed slightly, all nations' plans similarly involved a mixture of delivery models, by which I mean care homes, large sites, and primary care-based delivery, and that all four CMOs took a joint approach to advice?

A. Very much so. Absolutely.

Q. Did you also meet with ministers of the devolved governments as necessary?

A. Yes, absolutely.

Q. You talk in your statement about an effort to align data cycles and announcements between the four nations, so to release figures at the same time. How easy was that to achieve, please?

A. I have to say, in many ways when I reflect on what we had to deliver against, what I witnessed was the best of what Britain has to offer, ie, people set aside their political differences, especially when it comes to vaccine deployment which is obviously my narrow remit of the pandemic response, and worked really constructively together. We always knew -- and this was the challenge and it will come through, obviously, your Inquiry -- is we had limited supply, ie, the sort of predominant factor was this isn't going to be an unlimited supply of vaccine, and therefore how do you make sure that you have fair equity and protection according to expert advice from the JCVI, in terms of how we protect, you know, as many people as quickly as possible?

That was really important, and if there were, sort of, tensions, it was always around making sure that, you know, people understood that we are limited, constrained, dare I say, by what the Vaccine Taskforce has been promised by the manufacturers. And, of course, you know, as you can imagine, whether it's the protein vaccine from AstraZeneca or the mRNA vaccine from Pfizer

and Moderna, these are, you know, very fragile, complex manufacturing challenges. And that was always the constraint.

Q. Of the discussions between the four nations and decisions about how you would go forward, is that the context in which you're mentioning those constraints?

A. Yes, absolutely.

Q. I want to ask now, then, about the vaccine delivery plan, which was published on 11 January 2021, and you produced a Ministerial foreword jointly with the Secretary of State. But the purpose of that plan was stated to be explaining to the public how the supply of vaccines would be deployed. Prioritisation was one matter covered in the plan, which was effectively already agreed upon for phase I, when the delivery plan was formulated. Was it your view that the simplicity of a mainly age and clinical risk-based prioritisation system was the most operationally feasible for the deployment of vaccines?

A. Yes, but it wasn't simply relying on, "Oh well, you know, that's the simplicity of helping us operationally". It was relying on the evidence from Professor Wei Shen and his team at the JCVI that looked at every other factor that the virus impacts the human body, and very clearly the evidence is age was the

dominant factor as to whether you get severely impacted, infected by the virus. And so it was fortuitous, almost, that, actually, the evidence suggested that age is the best, most effective way to protect humans, the nation, and that also spoke obviously to the strength of the data system that we both had inside the NHS and that we built in conjunction with, you know, brilliant technology from Palantir.

Q. If we could turn now to the vaccine delivery plan and look at an overview of some of the planned routes through which vaccines were to be delivered.

INQ000399454, please.

This is the UK Covid-19 vaccine delivery plan. We see there publication date of 11 January 2021.

If we could move to page 7, please.

We see here under the heading "Places" that the top priority is to offer, at this stage, a Covid-19 vaccine to everyone in cohorts 1 to 4 by 15 February, through a network of vaccination sites. And there are there described at 2.16, three types of site: vaccination centres, large-scale; hospital hubs, using NHS trusts; and then local vaccination services, including primary care networks and pharmacy teams.

The hope, set out at 2.19, is that the growing network of the sites will rapidly expand in the days and

weeks ahead of the publication of the plan. But at that point, 96% of the population were within 10 miles of a vaccination service, it was estimated.

A. Mm-hm.

Q. And if we might look a bit more closely at the principles underlying access, please, to page 30, at paragraph 5.2 we see the scale of the task set out: "the biggest vaccination programme in NHS history" and that as at "7 January, the UK had vaccinated more people than the rest of Europe combined".

Looking next, please, at 5.3, the considerations underpinning access were perhaps obviously who should offer a vaccination, the geographical variation and diverse communities, access to transport, and ensuring that NHS services are safe and accessible for people throughout the winter period.

If we could then turn to page 33, please.

At paragraph 5.15, some large sites have been listed above and it is explained there that these sites were chosen as the mass vaccination centres for those ready to vaccinate large numbers, giving geographical spread.

And again, we have this marker of 10 miles within a vaccination service, the aim that, by the end of January, everybody will be within that kind of reach.

Is it fair to say that at this point, looking at the

choice of places and the aim to have everybody within 10 miles of a vaccination service, that at this point efficiency and scale was the priority for the programme?

A. I think that's right. If you remember what I said at the outset, the constraint is vaccine manufacturing, ie limited supply, which we knew was going to be the real challenge here, not just for the United Kingdom but for Europe and the rest of the world. And therefore, how do you maximise the protection of the nation? Hence why that sort of shaped the way we planned -- the way the team planned the deployment.

And I'm sure we'll get to it in a moment when we -- because obviously community pharmacies are very important in terms of community outreach, which was always also top of mind for me and the team. We were constrained by, you know, which ones could actually do the 1,000 doses a week because what -- when you have limited supply, what you don't want is vaccines sitting in fridges, nor do you want areas that might be able to operationalise quicker through the primary care network actually taking more vaccine, because they've been able to get started faster than other areas. Remember, we wanted to get the spread and the equity right, ie protect as many people as quickly as possible, in the fairest way possible.

Q. So it's about getting geographical spread across the country and also getting vaccines to sites that are actually able to deliver and store --

A. Absolutely right.

Q. -- the number of vaccines according to the requirements?

A. Absolutely.

Q. Is it also right that, in the early stages of planning, the specific storage needs of the Pfizer vaccine were a constraint?

A. Absolutely. As you know, the -- one of the vaccines, the mRNA vaccine, needed storage at, I think it was, minus 74 degrees, and when it was broken into smaller packs to get to the front line, again, you know, you know, the fragility and the ability to store, and therefore deploy, was a huge constraint.

Q. Was it also recognised that it was not enough to just run large central vaccination centres in the long-term, because, whilst that was the most efficient, it wasn't going to reach all communities?

If we could just touch on one final part of the vaccine delivery plan and get that document back up, please.

At page 40, this section of the plan deals with drawing on local authorities' knowledge of their communities.

Local authorities know their communities best and will play a key role, and highlighted there is the expertise of directors of public health and their teams, to address diversity and community development. They had a duty, local directors of public health, didn't they, to assist in the proper delivery of the vaccination programme?

A. Very much so. And again, you know, I thank all those directors. We spent a lot of time engaging with them. You've got to remember, you know, we were flying the plane while we're building it; right? Before this team came together, there was no -- you know, there's no manual, there's no blueprint for how do you deploy a, sort of, emergency national vaccination programme against a global pandemic.

Q. Yes, and thank you, we can take that document down.

That brings to us my next set of questions, which are really about the level of collaboration between local and central government. You attended a ministerial roundtable on vaccine uptake and engaging harder-to-reach groups in January 2021, on 8 January, and I just want to ask you want to that meeting. INQ000499497, please.

So this was, if we see on the attendees list on the front page there, attended by you and Lord Bethell,

a number of junior ministers, Baroness Dido Harding, and other officials. This was effectively notes of a roundtable discussion with the Department of Housing, Communities and Local Government.

If we could just look at page 2, please, under the "Discussion" section, "NZ", that's you, pointing out that:

"While initial rollout takes into account deprivation, we need to ensure we do not miss out on BAME communities, vulnerable groups and others as we progress through the cohorts."

And you were keen at that point to hear from others about experiences of rolling out Test and Trace to harder-to-reach groups as to how that could be operationalised best in vaccine rollout. And LB, Lord Bethell and DH, Baroness Dido Harding there.

A. Mm.

Q. If we just look at the suggestions that came back within that discussion, at the third paragraph down we see:

"DH -- some further lessons ... On the ground, we faced a huge amount of disinformation -- particularly on social media. Found it was often circulating in [particular] places ... able to feed [into] distrust ... Wish we had been more proactive with local authorities and involved them at an earlier stage ... Local

politicians are very useful and often know which community [and] faith leaders to talk to ..."

Keith Vaz is an example of helpful intervention in Leicester.

And the third sector, faith networks, are crucial. GP and community pharmacists are by far the most trusted health professionals in their communities.

Thank you. We can take that down.

So it was a clear lesson from the Test and Trace programme, wasn't it, that working relationships with the local authorities and local healthcare networks were going to be key to reaching these communities?

A. Very much so, and just to bring it to life for you, in Hackney, the Haredi Hasidic community, there was, you know, a real concern around vaccine hesitancy and not coming forward, and we were approached by the Hatzola ambulance, which is very much part of the community, and said, "Look, if you let us lead and you, the NHS, support, we think we can deliver against this". So on a Saturday night, you know, I showed up, actually, with Diane Abbott, who is the local MP, we watched people queueing up to come because they trusted the Hatzola. And within that community, there were lots of, you know, Muslim families also coming forward, because the community's pretty well integrated, and that was really

great to see.

We did the same with the Brent mosque, and after -- I think it was after Iftar, if I'm not mistaken, the families came in, and it's a trusted place, and that sort of work we were replicating around the country in churches and elsewhere.

Q. Can I ask, then, about communication with local authorities. You, I think, were made aware at the time of reports of local authorities' concern particularly in early to mid-January of 2021, that data was not feeding through to local authorities. And just so you have an idea of what I'm referring to, INQ000499498, please. This is an email chain dated 10 January 2021.

And if we just can zoom out a little. Thank you.

This email expresses concerns that really relate to data, and if we look at number 1, that:

"Locally, comms on vaccination delivery and progress can be patchy. At a local level... GPs [are] communicating with people, and the level of communication varies hugely, even within areas ... some ... frustration in the local tier due to lack of comms on what's happening with councils not heavily involved in comms and what equipped with the data to do so."

If we just come out there, please, to number 2:

"Local councils and Directors of Public Health are

not getting data on the rollout at a borough level and aren't being informed or able to accurately judge who isn't coming forwards."

And the next paragraph, please.

The recognition there, of course, that local authorities will be most useful, as we've recognised, in tackling hard-to-reach groups. Data access is important. Again, it's reiterated there.

Thank you, we can take that down.

Were you aware at the time of the concerns from local authorities in the initial stages that they weren't getting the data, and by which I mean they weren't getting sufficiently specific information on where there were areas of lower uptake within neighbourhoods, they might be neighbourhoods that were next door to each other that had very different levels of uptake and the very demographic information about those pockets of lower uptake so that they could understand who those communities were and then target the programmes that you have been explaining are so helpful towards those communities. And could you explain, please, as well, what you did if and when you became aware of that?

A. Yeah, no. Absolutely. Back to what I was saying earlier, we were, you know, building the plane while

we're flying it. And we knew that we will improve our data and of course the sharing of data, you know, in days and weeks. But what we need to do of course initially is make sure that we use the data to the most effective way of its use.

What I tried to do is make sure I engage with directors of public health, with local authorities, because the more that, you know, we can hear from them as to what their needs are, the quicker we can then -- and if you recall, as we got further and further into the vaccine deployment programme, you know, data sharing became better and better, but if you're asking me, you know, is there a lesson to be learnt? Yes, there is. The problem -- and, you know, I completely get where they were coming from at the time and today as well -- is if you're going to try and design a data system by engaging with everyone whilst you've got a virus ripping through the nation, right, you just don't have time. And it's one of those balance of, you know -- decision-making moments, where you have to balance what you're trying to achieve, which is protect as many people as possible as quickly as possible, by deploying as fast as possible, whilst being limited by supply, versus, sort of, designing the perfect data system that allows for all this stuff to happen quickly.

We knew we needed it, we knew it's a priority, but in all honesty I don't think we could have done it any better than we did at the time.

Q. Did the situation subsequently improve --

A. Yes.

Q. -- as that system but became --

A. -- that's my point.

Q. -- became more sophisticated?

A. Absolutely right. And data sharing got better and better because also we knew we needed local authorities to be engaged to get to the hard-to-reach groups.

Q. And looking to a future pandemic, I appreciate you left your post and moved on from this work in September 2021, but at the point that you left, were we in a better position --

A. Much better.

Q. -- should a future pandemic require, as it is likely to, the sharing of data between central and local government in that way?

A. Very much -- very much so.

Q. Just then returning to an issue that you have already mentioned, the use of pharmacies. And it goes, really, back to that local outreach approach. You were aware that there were concerns from the pharmacy industry, and indeed raised in one of those vaccine update meetings by

the Prime Minister, concerns about the fact that pharmacies were being under-utilised in the early days of the pandemic. If we could look, please, at INQ000234278.

This is a vaccine update meeting. In attendance we have the Prime Minister, Secretary of State, you, Dame Emily Lawson, and other officials in the NHS representatives. This is a group that met frequently, didn't it, to discuss updates in vaccine deployment?

A. Yes.

Q. If we have a look at page 2, please, paragraph 2, we've got the Prime Minister there questioning whether enough was being done through community pharmacies, and the explanation that was given by the NHSE was that the NHS had chosen to only use those pharmacies which could commit to distributing over 1,000 vaccines per week, and that the feeling was that average pharmacies would be far less efficient compared to other sites at that time. That was the experience from the flu vaccination programme. And it was explained that community pharmacies would be critical for reaching harder-to-access communities. So that was well understood --

A. -- (overspeaking) --

Q. -- it was just that they would be switched on, to borrow

the terms used in this meeting, as necessary, as those communities were identified.

Thank you, we can take that down now.

And in fact on the same day, I think, you attended, 7 January 2021, the same day as the email we've just looked at, a meeting with representatives from the National Pharmacy Association who stressed the importance of pharmacies reaching local communities.

So the issue here was that there was a service specification in place, certain requirements, 1,000 vaccinations a week also, to be open seven days, certain operating hours. It was only going to be possible for the largest pharmacies to fulfil those specifications in phase I, certainly at the earlier stages of phase I.

Do you think, looking at this in the round, that the balance, when it came to the use of pharmacies, that the balance between efficiency, wanting to reach as many people as possible as quickly as possible, and reaching groups where there was lower uptake, was struck in the right way?

A. Yeah, so that meeting was the weekly meeting we had with the PM, and -- a couple of things to say on that. One, the Emily Lawson plan as I refer to it, the NHS plan, always had deployment of pharmacy especially community pharmacies. That was already -- you know, to their

credit, the team understood that. I had obviously received additional representation which led to that meeting, by the way, on the same day that "We can do more, we can do more, Minister, why aren't you using us?" And I said, "Look, let me go through the plan again", and how much more can we pull forward? And credit, again, to the team, they went through it again and we looked at what more we can do, because we need it.

The constrained -- the constraint, I should say, and we were constrained by, the supply. Do you remember what I said at the outset? Right? What I can't afford, what we couldn't afford, is to simply want more community pharmacies to come on board when we had limited supply, where the vaccine would just sit in a fridge because they just can't put 1,000 jabs in arms a week, and therefore, we had to strike that balance and say, you know, as long as supply's constrained we have to deliver a system that can make efficient use of every dose, every vial of vaccine. Once we get to a place where we know supply is no longer constrained we can go much further than that.

And that was -- I think we struck the right balance in the work we did.

Q. I want to move on now to look more closely at the

consideration of vulnerable or marginalised groups and the steps taken to increase uptake.

Before rollout began, it was plainly anticipated by the government, wasn't it, that the uptake of vaccinations was likely to be lower amongst ethnic minority groups and amongst other vulnerable groups, and you understood that as well when you entered your role; is that right?

A. Very much so.

Q. A vaccine uptake plan was published on the 13 February 2021, signed off by you and by the Secretary of State. And it set out a plan to address the disparities in uptake and also to represent what steps had been taken to that point.

I don't need to repeat those principles which we have so thoroughly covered about the importance of local outreach and of trusted voices. There are a large number of examples of work within the vaccine uptake plan of what was being done or had been done in different regions and communities. Some of it was funded by the £23 million in initial funding in the Community Champions scheme. I'm not going to attempt to list them, as I say, in the time we have, but they include initiatives like mobile vaccination services, community and faith groups acting as information hubs,

networks of professional staff liaising with those working in care homes. Videos produced in acceptable format.

Is it fair to say that most of those initiatives went back to the principle of using trusted voices, people from the communities that the government is trying to reach who know what the concerns of their community are likely to be?

A. Very much so. What we realised quite early on, and if you're asking me one of the learnings is the use of data in the future, is, you know, when we saw obviously what we knew was going to happen, which is lower uptake, especially among ethnic minority groups, the knee-jerk reaction would be to say: let's have more walk-in centres because maybe these people, you know, don't want to make an appointment, give lots of detail, or go online and give lots of detail.

When we looked at the data, there were more walk-in centres in those postcodes with the low uptake within, sort of, five minutes' walk than there was in Stratford-on-Avon where we had very high uptake. And therefore, you know, we could have easily chucked another half a billion quid having more walk-in centres but we wouldn't have solved the problem.

We then had to go back and do more research and the

research then very clearly found that actually the best way to do this is, for example, the Community Champions programme, ie, clinicians, preferably clinicians, working within the health service who have been vaccinated, from those communities, actually then communicating with their local community, at times going door to door and saying, "Look, I'm from the community, I've taken the vaccine, let me talk to you about the vaccine, how it's been developed, why it's safe and why it will protect you and your family." And that was a huge success.

Q. Just moving on from those overarching approaches to a particular issue faced by some groups which is addressed in the vaccine uptake plan, please could we have INQ000234748 up.

This is the vaccine uptake plan but I think we may have the title page slightly cut off there.

If we could go to page 11, please. Oh, we're already there, I've been anticipated. Fantastic.

So "Being invited for an appointment".

A. Mm.

Q. This part of the plan recognises:

"Not everyone is registered with a GP. This includes those experiencing homelessness, people who may not live in a fixed location, refugees and those seeking

asylum or simply because an individual chooses not to."

And then it's explained that:

"... [NHS England have worked] with partners such as Groundswell and Friends, Families and Travellers have launched the 'Everyone is welcome in general practice' initiative which encourages and supports people to register with a GP."

Thank you, we can take that down.

Was this a particular issue, and we can see from the mention of the group Friends, Family and Travellers, a particular issue within Gypsy, Roma and Traveller communities, that of not being registered with a GP?

A. Yes, but also obviously there are other communities who may not be registered.

Q. Yes, and those with uncertain migration status, for example?

A. Uncertain migration status, and people who, for example, who actually was the other, I guess, the other, you know, extreme of the demographic who are very wealthy and choose not to -- have chosen historically not to register for public health, but --

Q. Focusing on those vulnerable groups --

A. Yes.

Q. -- is it right that this was a longstanding problem, inclusion in healthcare generally for people with

uncertain migration status, Gypsy, Roma, Traveller communities in particular, that might be linked to a permanent address or might be linked to lack of inclusion in healthcare more generally? It wasn't unique to the pandemic, was it?

A. No, you're absolutely right.

Q. And I just want to ask you about some actions that were taken by the government.

If we could have INQ000401097 up, please.

This is a letter from you dated 4 June 2021 to some representatives of access to healthcare organisations, expressing concern, essentially, about people with uncertain immigration status or vulnerable people being deterred from seeking treatment for Covid-19. And you explain there at paragraph 3 in your response:

"... it is very important that people are not deterred from seeking treatment for COVID-19. The Department therefore took early steps to ensure that diagnosis and treatment for COVID-19 is free for all, including anyone living in the UK without permission."

Just pausing there, is that a reference to the charging regime that applied to some forms of NHS treatment but from which Covid-19 treatment, including vaccinations, was exempt?

A. That's correct.

Thank you. We can take that down.

So it's clear from this letter what the legal position or the government's position was.

A. **(Witness nodded)**

Q. But my question is: was that sufficiently communicated, not just to healthcare providers, who may receive this letter, understand it, file it away, but to the people in those communities, so that they knew of their right to be registered even if they didn't have the right paperwork, and they knew that they weren't going to be charged and that their information wasn't going to be passed on? How was that achieved?

A. Yeah, absolutely. I mean, actually, obviously, both things, ie that they know they can come forward and get protected, but also, you know, for the whole country, for -- it's in the nation's public health interest that we vaccinate all groups. So we had a whole series of interviews, communications, including with myself, going onto, you know, news media and radio that was very much, you know, listened to by those particular groups, to really reassure that I'm the minister, you know, I'm basically saying to you: look, just walk in and get vaccinated, get protected, and you're safe and you don't have to fear the state, effectively.

Q. Do you think more could be done in that regard now and

Q. But you recognised that there might be a deterrent effect attached to the perception that people may be charged or indeed that their information might be shared --

A. Correct.

Q. -- with the Home Office as part of those charging provisions.

Just looking at the next paragraph:

"I can assure you that no immigration checks are needed for overseas visitors when they are tested, treated, or vaccinated for COVID-19."

If we could just zoom out and see the whole page, thank you.

"NHS providers have also been advised not to share any information with the Home Office or to ask for status of those accessing services related to COVID-19 treatment ..."

The next paragraph makes it plain that:

"An NHS number is not needed to make a booking for a COVID-19 vaccination ..."

But, "individuals do need to be registered with a GP".

And whilst there was an understanding that not everyone was registered, efforts were being made to reach out to those people.

in the future?

A. I think we did really well, you know, in terms of getting the message across, that people can just come in and get protected. I don't think we left much, you know, that we didn't do. Of course, there's always more that can be done in terms of, you know, if you had the luxury of time to plan, but we didn't have that.

Q. Right. I'm going to move on to the interlinked issue of misinformation and disinformation.

Just in summary, the Inquiry has now heard from a number of witnesses that the government's approach to dis- and misinformation was to not engage directly with it, to try to understand the causes of hesitancy, and you explain in your statement that you agreed with this approach, that public engagement with misinformation risks legitimising it.

Would you agree, tying together, really, those issues of misinformation, disinformation, low uptake, that inequalities in vaccine uptake and misinformation and disinformation both really boil down to trust: that those parts of society that are less trusting of government health initiatives are more likely to look to alternative sources of information and are more exposed to mis- and disinformation?

It's clear from your evidence and from the evidence

that the Inquiry has heard from others that lots of efforts were made to try to build that trust and to address those issues of uptake and mis- and disinformation, but the evidence that the Inquiry has received so far appears to suggest, including from experts in vaccine coverage, that, despite those efforts, there were still marked disparities in uptake, particularly in respect of some ethnic minority groups, and I think you recognise in your statement lower vaccination rates in some groups still persist, despite the efforts to address inequalities.

So why do you think that those disparities persisted, despite the efforts that were made?

A. Yeah, and I would just add one other thing. So we deliberately, you know, didn't engage with anti-vaxxers, but we also then deliberately wanted to engage with vaccine-hesitant, you know, individuals and groups, because of that misinformation and disinformation, that that can impact their decision. And I think -- and, you know, without having -- going over each and every initiative, but I think we really did some really good things in community, especially engaging with those from the community who happened to be in the health service, clinicians and others, because they would have the most trusted voice in the sort of hierarchy of trust with the

state.

But unfortunately, you know, people still -- and you see it even today, right -- people think -- if you think about vaccines as a whole, not just the Covid-19 vaccine, it's been an extraordinary piece of human ingenuity and innovation to protect, you know, humanity from all sorts of disease, yet there is still, today, people who choose not to protect their children, say, with MMR or any other vaccine. So you're always going to have, I guess, residual resistance, but I think we really did, put in the hard yards to try to get as much information into the hands of those people who were hesitant, but also making sure that the people who were, you know, put out there to talk about it, whether it's, you know, Jonathan Van-Tam or Chris Whitty or, you know, chief nurses, were people who that the credibility, had the scientific credibility as well and it's not just politicians who are going out and saying, "You must get vaccinated."

Q. I'm going to move on to a separate topic entirely now, which is the cancellation of the Valneva contract.

In September 2021, the UK decided to cancel the vaccine supply contract with the biotechnology company Valneva. It had developed a Covid-19 vaccine candidate, which was the only inactivated whole-virus candidate

within the VTF portfolio. And you received advice about whether or not to go forwards with that contract.

If we can just bring it up on screen, please, INQ000514013. And the second page, please.

We can see that this is an advice to you and the Secretary of State at the time, Sajid Javid, regarding Valneva and the decision on termination dated 9 September 2021.

And if we could go to page 4, please, we should have paragraphs 8 and 9 there.

"8. Expert advice from within VTF and DCMO is that it is highly unlikely a significantly better performance would be seen from the vaccine as a primary regimen, or that an Alpha variant vaccine would show a much more improved boost performance."

Then at 9:

"Under the circumstances and having taken advice ... we are recommending that we terminate the Supply Agreement ..."

Then the position is reserved on Clinical Trials Agreement.

If we could then, please, to page 7 at the bottom, there are some communications at paragraph 25, some advice which arises that:

"... we expect that Violet [Valneva] will be obliged

to announce the termination of the contract to the market. We will work with them on framing of this and options to include the positive language around how we will work with them on alternatives use for the Livingston facility."

So that was the facility in Scotland that was being used for production. Thank you.

Then, please, page 8, paragraph 28, we see the conclusion of this advice, that:

"[The] VTF should engage with [Valneva] after markets close ... to explain [that the UK] intend[s] to terminate the Supply Agreement ..."

And engage, we see at (c), on alternative plans.

So we can take that document down now entirely.

So the advice includes, then, a summary effect of the cancellation and -- in terms of what effect it may have on Valneva's business and also the business of the Livingston facility, recognising that, as we've seen in that advice, it was the VTF itself that recommended the cancellation. You then considered that recommendation.

Concerns have been raised about the cancellation of the contract by number of Module 4 witnesses, including former Chair of the Vaccine Taskforce, Dame Kate Bingham, and also Dr Clive Dix, and concerns have been raised about core participant groups as well. Dame Kate

Bingham describes the contract as inexplicable and that it was a shift from positive cooperation with industry to an adversarial approach that sent the worst possible message, to borrow her language, to any future UK industrial investor or life science partner.

So the question is this: to what extent was consideration given to the UK's wider relations with industry when deciding to cancel the contract? That is, the effect on relationships with the pharmaceutical companies that the UK might work with in the future, their willingness to work with the UK if it was considered that contracts taken on at risk might be cancelled in this way. Did you consider that?

A. The simple answer is yes. You know, I don't know how much of my background you know. I was -- I have very much a commercial background before entering politics, and, on the face of it, an inactivated virus technology could have, should have maybe worked. The VTF didn't deliver their advice out of gut instinct; it was based on evidence. And I attended that meeting with the -- with Jonathan Van-Tam, the Deputy Chief Medical Officer, and the expert team, who took us through the data. You know, as a booster, it just didn't work. Even compared to the placebo. Right?

And therefore, it was a really hard decision to

make, but it's evidence-led and based, and that's the only way you should make decisions in government. Or even in the private sector. You know, in the commercial world, you know, if I was the leadership at Valneva, the evidence is the evidence. I can't change those facts, and I think it was absolutely the right decision.

I hear what Dame Kate Bingham says. I have huge respect and regard for her experience, capability, but in this case I think we're conflating two different things and delivering the wrong conclusion, ie, you know, working with the industry and supporting the industry to make us the best place to invest in pharma, in new technologies, that's, you know, a very different consideration to just telling the truth to Valneva and saying: "Look, the data doesn't support us supporting this vaccine, neither as a booster, nor as a future vaccine, because there are just better technologies. And I think you're hiding behind your finger if you think otherwise."

Q. Finally, then, turning to your recommendations or the lessons learned which you set out in your statement. You described the use of data as an important lesson learned. Is that to do with the positive lesson to be learned from the sharing of data on a daily basis, daily figures, and transparency with the public which you

think encouraged confidence of the public?

A. Back to where we begun, you remember what I was saying to you about how thorough and well-designed the deployment infrastructure was put together by Emily Lawson and her team? By sharing data daily, which was my -- you know, my big passion was to say: look, we've built this amazing piece of technology with Palantir, called Foundry, where the minister can, every morning -- I can see every morning, literally, who's been vaccinated where, almost in real time. Almost in realtime, by flicking the switch. And sharing it with the nation I actually think was one of the best pieces of innovation, in terms of carrying the nation with us. Because, remember, we've locked the nation down, everybody was really struggling and suffering. I couldn't really go on television every night and say, "Trust me, we've done adequate numbers today, you know, I'll tell you in a couple of weeks' time what we've done". It just wouldn't have worked.

When we flicked that switch and opened up the data, and as the nation can see, you know, as we began to really scale the deployment and build the numbers, the sentiment very quickly flipped from despair to hope, and then to belief that, you know, we are going to deliver this, we're going to do this and we're going to do it

together. And then it obviously filtered back into confidence, and people actually coming forward and getting themselves vaccinated.

So I think that was probably one of the real lessons of this, is that level of transparency. You remember, we used to adjust the data every three days and say: look, we undershot or overshot the numbers? And one of the discussions we had before going to daily release of data was to say: you know, are we going to impact the NHS brand if the data isn't perfect?

And my very strong argument was: it doesn't need to be perfect; we just need to be transparent, because we've got such a great team and such a, you know, fantastic plan, we will do this and we will demonstrate to the nation, and then that positivity will flow through into allowing us to get on with the job for the rest of the deployment.

MS STEPHENSON: Mr Zahawi, thank you, those are my questions.

LADY HALLETT: Right. There are a few more questions for you. Mr Wagner, over that way.

Questions from MR WAGNER KC

MR WAGNER: Thank you, good afternoon. I represent Clinically Vulnerable Families which does what it says on the tin: represents the clinically vulnerable, the

clinically extremely vulnerable and the immunosuppressed.

I just have one question to ask you and it relates to vaccination centres. CVF members report a number of concerns surrounding the safety of vaccination centres for clinically vulnerable people and severely immunosuppressed people which they say presented a practical barrier in some circumstances, and the kind of things that they talk about are poor ventilation at the centres, the distances they were required to travel which could lead to having to get on public transport or travel in cars with people at close quarters. And they also found that other patients and healthcare workers would frequently remove their masks in the centres.

The first point is, did you hear about those kind of concerns in relation to the vaccination centres and accessing those centres?

A. So I -- obviously, in my role as the vaccine deployment minister, met a number of groups representing the clinically vulnerable, and not least, by the way, and didn't get much of a mention today, but I have to say we initiated an engagement with MPs and peers and we'd get hundreds, in the early days literally almost every MP would be on the call and I would be flanked by Jonathan Leach from the NHS and Professor Anthony Harnden from

the JCVI and we'd take all questions, including from their constituents who are clinically vulnerable, and actually, that was a great piece of innovation, because it was a fantastic radar screen where we picked up stuff very early, including vulnerability of pregnant women, for example, and prioritising clinically vulnerable with the 70 to 74 age group, ie, very early on in vaccination.

I don't recall concerns around the actual vaccine sites, vaccination centres. Most of the feedback was around what more were we doing to work with the pharma manufacturers, with the vaccine manufacturers, to bring forward some other drugs to protect the severely clinically vulnerable? That was one of the big things that they were worried about. And, of course, could we, later on, make sure that we can vaccinate them if they can't travel at all, for example.

But not the point about the vaccination centres, from recollection.

Q. Looking back now, and just assuming that those concerns were valid in certain circumstances, do you think there was a failure to ensure that the larger vaccine centres were safe enough, convenient enough, and equally accessible for clinically vulnerable people?

A. If you're asking me could we always, you know, do more?

Absolutely. But my experience of those centres and the people that worked in them, they took their responsibility incredibly seriously, and did everything in their capacity to be places that will protect those that are clinically vulnerable. So I think in many ways, I guess, you know, going forward, can we do more? Of course. You know, we can go back and learn exactly how, you know, how we can do better for the clinically most vulnerable in a pandemic, but those centres were, in my view, really, you know, built for safety.

Q. Could you think of ways the vaccination centres could have been better designed for clinically vulnerable people?

A. I'm not -- you know, I rely on a lot of experts, right, and I think I'd be mis-answering you or mis -- you know, mis-speaking if I said to you, "Oh yes, I'm an expert in this, I can tell you this is what to do." I think it's one for the medical profession. If we can improve that, then we should absolutely look at it. I'm a decision-maker as a politician, I would, in each and every of those cases, I'd say to you, if we're designing for the future, let's talk to the representatives but also the medical experts.

MR WAGNER: Thank you.

LADY HALLETT: Thank you, Mr Wagner.

Ms Naik, who is usually over that way. There she is.

Questions from MS NAIK KC

MS NAIK: Thank you, Mr Zahawi, I hope you can hear me. I represent four organisations who comprise the Migrant Primary Care Access Group. I just wanted to ask you a bit more about what you said in your witness statement about editing the vaccine uptake plan that was published in February 2021, and I appreciate that Counsel to the Inquiry has taken you to some of those parts, but you specifically said that you provided comments on the draft to show -- to include the importance of showing what steps were being taken to address barriers to undocumented migrants and those with unsettled immigration status. But the only reference in the actual plan is to -- which Counsel to the Inquiry took you to, was just in relation to the difficulties that people might face being registered with a GP. So there's no specific mention in the actual uptake plan of undocumented migrants or those with precarious immigration status. It refers to refugees and those seeking asylum.

So what specific steps were you referring to in your witness statement? What targeted steps, other than those that you've already told us about, for example

your national radio appearance, but what else was there that you actually did?

A. Well, I think you have just referred to it again. So other than the plan, we made sure that from the top, ie, from the minister, myself, and through the organisation, we, you know, engaged in outreach, including myself, you know, engaging with media outlets that those particular groups we knew were listening to, were reading, to be able to say very clearly, "Look, you're hearing from the minister that you can come forward safe in the knowledge that all we're trying to do is protect you. We're not looking at your documentation or legal status."

And that was, I think, probably the most effective thing to do which is walk the walk, not just talk the talk.

Q. I mean, it's hard to pin down any other examples apart from that which you've just referred to about your national radio appearance. You were referred by Counsel to the Inquiry to your letter, the 8 June letter 2021, which referred to "No NHS number being required", but you did need GP registration, and then you set out in that letter, which we've just had up on screen, there was -- overseas visitors could have -- be registered as temporary patients if they were here for over 24 hours and less than three months, but it's complex and hard to

understand for people who were outside of those groups, and we have evidence that people were still being refused registration erroneously because of a lack of documentation.

So how effective were those communications when the NHS charging and data-sharing regimes remained in force?

A. Again, I would just repeat that we can always learn the lessons of the past, of the pandemic, to do things better in the future, but I had -- I did not see resistance from the NHS leaders to what we were trying to do, which was reach those hard-to-reach groups. Quite the opposite. Incredible support and time in engaging with those -- you know, yours and other organisations that you represent.

Q. And did you see any impact of the hostile environment health policies on those considerations in terms of impact?

A. No, I didn't.

Q. So your -- Ms Badenoch just gave evidence just before lunch and she said that for people who are undocumented migrants or illegal immigrants, that their interactions with the state may be minimal to none, they would be worried about being deported and she said in terms, "We cannot adjust our health system, in my view, to undermine borders and borders securities, that's just

something we need to accept". So your positions seem to contradict one another, either --

LADY HALLETT: I'm sorry, I'm going to have to stop you, Ms Naik. I didn't give permission for this question, I'm afraid.

MS NAIK: Well, my Lady, that, we say, is part of the contradiction between this --

LADY HALLETT: And also pointing to this witness that there may be a conflict between them. I have Mr Zahawi's evidence. Thank you.

MS NAIK: Thank you, my Lady.

LADY HALLETT: Thank you very much. That completes the questions that we have for you, Mr Zahawi. Thank you so much indeed.

Given your other roles during the pandemic, I'm not sure I can guarantee we won't ask you to help us again. I suspect we may already have done, have we, I don't know, in education or finance --

THE WITNESS: Not yet.

LADY HALLETT: Okay, well keep your fingers crossed. Thank you very much for your help.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: I shall break now and return at 3.05.

(2.52 pm)

(A short break)

(3.05 pm)

LADY HALLETT: I hope you were warned that you would be the last witness today.

THE WITNESS: I was warned, thank you.

LADY HALLETT: Yes.

DAME EMILY LAWSON

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4

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

A. My full name is Emily Jane Ruth Lawson.

Q. Thank you very much, and thank you for attending today and also for the provision of your witness statement, dated 8 August 2024.

Dame Emily, can I start, please, with your role, and the history of your role, in the NHS.

After a fairly lengthy career in industry, you -- I think you were a director at Morrisons and then the Chief People Officer at Kingfisher. You were employed by NHS England from 1 November 2017.

A. That's right.

Q. As National Director for Transformation and Corporate Operations. I think you were concerned with the integration of NHS England and NHS Improvement.

A. Yes, that's right.
Q. Then on 1 April 2020, so shortly after the commencement of the government's response to the pandemic, you were made Chief Commercial Officer of NHS England and NHS Improvement, as it then was?
A. Yes.
Q. Did you, on your appointment as Chief Commercial Officer, immediately become concerned with the other terrible issues concerning and the difficulties of supplying PPE and ventilators, the whole of that supply chain, and procurement and delivery issue?
A. Yes, in fact slightly before being confirmed in the role, I got involved in those.
Q. During your time as the Chief Commercial Officer, concerned with PPE and ventilators, did you have occasion to work with -- and I want to specifically ask you about them -- a part of the military called the 101 logistics battalion?
A. I did.
Q. We've not heard much, in fact any, about 101 Log, as they were then known. Who are they?
A. So, 101 Log is a logistics brigade, as you've said, in the army, led at the time by then Brigadier Phil Prosser, now Major General Phil Prosser, and they were brought in in March 2020 in order to

support the supply chain issues that were going on with PPE, and worked incredibly closely as part of that integrated team through the summer of 2020. And so when I took over -- sorry, I might have skipped ahead.
Q. No, not at all.
A. When I took over the vaccine programme at the beginning of November, one of the things I did was to go back using the MACA process.
Q. Just stop there. You've just thrown an acronym into the moving parts.
A. I apologise.
Q. MACA, is that the military assistance to civilian authorities process, by which the military has to be formally invited to help us out when we're in trouble?
A. That's exactly right. So that was done through the DHSC. I asked for support again from logistic support from the army; obviously I couldn't specify exactly who or exactly which brigade was sent, and I was obviously delighted, two weeks later, that they decided to send 101 Log and Phil Prosser again.
Q. Did they help you with, and were they of great importance in relation to, all these issues: supply and logistics; the logistical planning -- because this was an incredibly complex process by which the population of England was to be vaccinated; they acted as vaccinators

when you needed extra hands on deck; I think they transformed and set up some of the local vaccination centres. Is that right?
A. Yes, some of that was not 101 Log. Some of that was other army groups. But having 101 Log in the vaccination team, like, right in there with us, every day, they performed, you know, many of those functions you said. That operational discipline as well as the specific expertise in supply chain logistics was absolutely foundational to how we ran the programme.
Q. I don't wish to intrude into the topic of when and how the military should be invited to assist civilian authorities, it's a bigger issue, but may we presume from what you've said that the military assistance you received in relation to PPE and ventilators, and in relation to vaccination, was of incredible value?
A. Yes, invaluable.
Q. On 9 November 2020, you were then made national director for Covid vaccine deployment in NHS England. And it's plain from what you say in your statement that that was a hugely important policy role. You were at the head of the pyramid. You also became, did you not, what is known as the Senior Responsible Officer for vaccine deployment and take-up?
A. Yes.

Q. We've seen reference to "SRO" elsewhere in the paper. What is the SRO?
A. The Senior Responsible Officer is really the person who has to hold everything together. It doesn't mean they are necessarily commanding all the individual pieces every day, and we can hopefully talk about the multiple pieces that came together to help not just, you know, from the NHS, but the Senior Responsible Officer has to be the person that says, "We're doing it this way", hopefully having brought everybody with them, and takes responsibility for executing according to the decisions that ministers and sometimes, in this case, the Prime Minister had made, and being a safe guardian of taxpayer money in terms of doing that at the right value-for-money judgement.
Q. And responsibility is key, isn't it? It's about accountability, the Senior Responsible Officer is ultimately the person accountable for the outcome of, in this case, the vaccination programme?
A. That's right.
Q. All right. And is that why -- and we'll hear witnesses, of course, from Scotland, Wales and Northern Ireland shortly -- they were the respective SROs in each of those nations?
A. Yes.

Q. You were responsible, ultimately, for every aspect of the deployment, so from the supply chains to the vaccination sites, the running of NHS England, insofar as the deployment was concerned, operations, security, governance, reporting, and the inconsiderable issue of the management and payment and deployment of the workforce.

Why was the SRO within the NHS? The NHS is plainly concerned with routine immunisation. Was that why the SRO was embedded -- to use a terrible modern expression -- within the NHS as opposed to, for example, being within the DHSC, or having an external head of a taskforce or maybe operating the system from within Public Health England? Why was it the NHS that was at the heart of it?

A. So absolutely, as you say, vaccination is part of the bread and butter of the NHS. We do that every day. We're responsible, under Section 7A, for discharge of the -- of vaccine, immunisation and, indeed, screening programmes. I think, even more broadly than that, though, the NHS is unusual -- NHS isn't part of government, but is a public sector body that operates.

So the NHS is, you know, 1.3 million people who deliver stuff every day. There aren't that many places in government, whether they're arm's length bodies like

NHS England or, for example, HMPPS in the prison service, that actually run things. And the critical, in my view, one of the critical parts of the vaccine deployment programme is we were operators figuring out how to effectively deploy something, you know, incredibly important to the health of the country and where health and then local relationships, which the NHS also has, were absolutely central to our success.

Q. And I suppose a lot of it comes down to the sheer scale and ability of the NHS. It's a massive administrative body as well as a health provider, and it's also within and without government. It covers a very broad range of functions.

A. That's right. I mean, it's multiple organisations, and I know you've addressed the complexity of the NHS set-up previously, but -- so within that, you have commissioning, you have delivery, you have policy and strategy making. We can come back to some of the pieces we had less of, like supply chain expertise, for example, but this is -- the NHS brand and that consistent relationship we have with each other has proven to be, through this, an incredibly powerful force for getting things done, for creating an aligned purpose.

Q. And the NHS as a unitary body across England, and of

course, similar situation, similar systems in the devolved administrations, is an incredibly effective beneficial body both in terms of providing health services but also, by way of brand recognition, and --

A. Yeah.

Q. -- countering, in this case, vaccine hesitancy?

A. I think that's right. There is an "and" there in that the NHS is an incredibly powerful, highly recognised brand, and for some groups, as we learned during the pandemic, it's not -- no organisation is really trustworthy, because of previous experiences. So yes, it is incredibly powerful and we had to reach outside the NHS and its heavy brand in order to make sure we were reaching everybody. It was both at the same time.

Q. We'll look at that in a moment.

So may we presume, Dame Emily, that you would strongly recommend that in the face of a future pandemic, requiring national population-level vaccination, it is the NHS that leads the charge in the way that it does with routine immunisation?

A. Yes, I would.

LADY HALLETT: Can I just ask you some more about that, Dame Emily. You had a commercial or a private sector background. To what extent did that help you? You said the NHS should lead in future, but the NHS had the

advantage in this last pandemic of people like you who'd also had substantial private sector experience.

A. Honestly, I think it was really helpful. I think I was incredibly lucky to be given this job but I was also in the right place at the right time, and all of that experience I've had, you know, through my scientific background, through the private sector, all of that came together to enable me to do a good job leading all these different people with hugely valuable and different forms of expertise. So it is both.

I think a public sector ethos of wanting to deliver a life-saving intervention was equally powerful, if I put it that way.

LADY HALLETT: Thank you.

MR KEITH: When you became the national director on the 4 November -- I think you were asked on 4 November, you were appointed on the 9th?

A. Yes.

Q. When you were appointed, presumably a great deal of planning work and practical measures had already been put into place.

A. Yes.

Q. And therefore, presumably, a great deal of work had been done on identifying vaccination sites, the design of the pods, as we'll see in a moment, the supply chain

arrangements, the booking system, the recording of vaccinations individually, and on communications. So the structure was in place. But what were the three main challenges in terms of getting it from that position on 9 November to actually delivering the first vaccination on 8 December?

A. So the week that I took over was the week that Pfizer data was published saying that the vaccine was effective. So it went from being a theoretical possibility to: actually, this was going to happen. And as you've mentioned, there were lots of component parts that had been worked through. So the pod system, et cetera, et cetera. Because of the level of uncertainty, which actually persisted through November, the novelty of this vaccine, a lot of final decisions had yet to be made, in terms of particularly given how the vaccine might be able to be transported, would have a major impact on what centres could actually distribute it, what training people would have to have, et cetera. All of that remained to be done.

Q. So just pausing there, by way of example, Pfizer had to be kept at minus 70 or thereabouts. It wasn't, of course, given authority until --

A. The 2nd of --

Q. -- 2 December, and at the beginning of November, you

wouldn't know therefore, what ultimately you'd have to put into place in order to be able to cope with that requirement?

A. Yes. So we had to develop options, and that novelty, having never seen this kind of vaccine before and the fragility of an mRNA vaccine surrounded by its lipid molecules, meant that until we saw the data from Pfizer, until MHRA provided that authorisation on the 2nd, we didn't have clearance to transport it at anything other than minus 70. Minus 70 is not a standard way to transport medicine so there wasn't an established supply chain to do that, and we had the tension between the cohorts that were most at risk, that JCVI had defined, so cohort 1, so care home residents and workers, and then group 2, which was those over 80, and health and other social care workers, the only place we knew in mid-November we would be able to get the vaccine to were hospitals that had minus 70 freezers.

Q. We'll come back to that in a moment, and why therefore you focused on hospitals at the beginning of the deployment process.

A. Yes.

Q. In relation to staff, were you enabled to employ at risk, that is to say, look forward and say, "Well, we're going to need this number of staff for the purposes of

the rollout starting at the beginning of December. We can pay for their deployment and we can bring them on board?" Or did you have to wait?

A. No, we were able to identify and the team had done quite a lot of work before I arrived on how many staff would be needed depending on the volume of vaccinations. What we couldn't do is train them, because obviously what was going to need to be true about how you dispense this vaccine wasn't known until the beginning of December, but the theoretical modelling, the specific roles within a vaccine centre, for example, that was all created theoretically around the time that I joined.

Q. The third area you identify in your statement as being particularly challenging was that of process, and you know where I'm going to. You refer on multiple occasions to the fact that, to use the terrible expression, the deployment process had multiple stakeholders. You appear to have spent a great deal of time speaking to other people, updating other government departments, getting input from the DHSC, the Vaccine Taskforce, the Cabinet Office, the Treasury, Number 10, DLUHC, I could go on.

Was an optimum process of governance and reporting to other parts of the government in place when you joined, or did you have to try to alter the reporting

obligations?

A. I needed to alter it. I'd spent the first week doing what I was asked to do and attending all of the different meetings, because I wanted to learn, as much as anything else. And one of the things I noted in those meetings is everybody would ask me how they could help. Everybody wanted this to be successful, and I'd say, "You know, the one thing you can do is cut down on the number of governance meetings I'm going to", and everybody would say, "Absolutely, definitely, we should simplify that, but not mine. My meeting is really important."

So I got to the end of the week, added up that I had spent 24 hours just in governance meetings, so not actually fixing anything. And I said, "No, we need to streamline this, we need absolutely to be held to account, this is one of the most important things the country is doing and it's a lot of taxpayer money, I totally get that, but can we do it in a way that also enables us to get stuff done, and put those two needs together?"

Q. You must have reflected why, perhaps in our system of governance, perhaps in many systems of governance, there appears to be a need for so many meetings, so many rolling iterative submissions to be made, so many

updates, reports, meetings with stakeholders, actions. It appears to become a very heavy written process of bureaucracy imposed on you trying to put something incredibly valuable and practically important into place.

A. Yes, and I think there are several things there. One is just the level of importance. It was so important to everybody. The other was the funding, as I've mentioned. Then the other thing is, each of the groups that you mentioned had a different sometimes overlapping but different need, right? VTF needed to know that what they were doing was actually going to happen, the Cabinet Office had an overall assurance role. Number 10 obviously wanted to make sure this was going to be successful. The Department of Health had a critical, you know, policy and oversight role. It wasn't that HMT needed to take charge of the money, it wasn't that any of those things was unreasonable, it's that they were additive rather than complementary and I thought there was an opportunity to streamline that.

Q. So you did?

A. So -- yes.

Q. You had, within the NHS England structure, for vaccine deployment, a mission statement --

A. Yes.

Q. -- and the Inquiry has noted that the Vaccine Taskforce had a mission statement. They appear to be associated with successful outcomes. What is the meaning of a mission statement and why does it help to have a mission statement?

A. I've referred in my answer just now about the novelty point that lots of component parts had been worked through, you know, the people sell, the clinical sell, everybody was doing good work. But it had got stuck because when you tried to add those pieces up, it wasn't clear how to make the right decision, right, that did vaccinate the right cohorts, that was technically doable, that was doable in a supply chain. And so I wanted something that really, in a very synthesised way, was really clear about what we were for so that when we put things together, those difficult trade-offs about this cohort here versus there, whatever, we had a clear and agreed structure that said, "Well, so long as it's doing this, it's the right answer."

So it both enabled different perspectives to come together and for us to make those trade-offs but also, I couldn't be in every decision that my team was making and they were deeply expert people. They needed freedom to be able to make decisions without me and again, they could say, "Well, if it's doing this, then it's the

right decision."

So it was a marshalling cry.

Q. So in a very complex, necessarily, part bureaucratic system, it gives everybody confidence to make a decision?

A. Yes.

Q. And it gives them a steer as to what the correct decision is likely to be?

A. That's right.

Q. All right. You had in this system seven regional directors of commissioning who were the heads of the regional teams. Were they responsible in each region for every aspect of deployment from the technology, the tech, the data, strategy planning, sites, supply chains, everything?

A. I just wanted to go back to the mission statement for a second -- sorry, there's one extra thing --

Q. Yes, of course.

A. -- and then I will answer that question as well. The other thing was about -- give people something to be excited about and to feel proud in. I think it's quite easy in these conversations to think about the things we can touch and feel, the processes, the reporting, et cetera, but how people felt about being part of this was also really important, and I think the mission

statement was helpful for that.

Q. Your long career in HR must have been of great assistance in that regard?

A. Back to the RDCs. The RDCs were responsible for the deployment of the programme locally which did mean things like working with local systems to identify the right sites for vaccination centres, they were doing, you know, GP engagement locally that kind of thing. They weren't responsible for tech development or for, you know, clinical policy, et cetera. That wasn't created locally. There were some things that were created nationally they would then deploy and then some things they were, sort of, pulling up, if you like, from the local level.

Q. Would you recommend the use of -- would you recommend the use of regional directors in the future in the next pandemic if there's a national vaccination programme, where each of those directors has more or less full autonomy within their area?

A. I wouldn't say they had full autonomy within their area; I would say they played a critical, sort of, corralling and decision-making function, but it was not the case that at any point -- I don't think they would have suggested it to me, but if they'd come to me and said, "Right, in the northwest we're not going to -- you know,

we're not going to have any vaccination centres", for example, we just wouldn't have done that.
Q. All right.
A. So just to be careful with the language. I absolutely needed that connection between these single, massive decisions nationally, and the real intelligence that said, you know, "If you use that GP site in north Bristol, you're going to need another one here because nobody is going to cross that A-road", kind of thing. But they were the bridge between what we could see nationally and what they knew, and relationships they already had and brilliant work that was already ongoing in some places with individual communities. They provided the bridge that enabled us to do both.
Q. So they were more closely connected to their local communities, they had the local links to directors of public health, for example, and they knew the best sites for vaccination as well as how to get in amongst the local communities in order to improve take-up.
A. And if they didn't know it themselves, because some regions are massive, obviously, they had the connections to the ICSs or the STPs, as they were, and to the LRFs and could encourage those local discussions to happen.
Q. One of the core directives, if I may use that word, that you put into place, was that no one more than -- no one

would be or should be more than 10 miles away from a vaccination location, excluding, of course, housebound people.
A. Yeah.
Q. Was that a very different approach to that which is ordinarily used in the context of a routine immunisation?
A. Yes, partly because routine immunisations will tend to take place in primary care, which is, by definition, more local.
Q. Because it revolves around GPs and --
A. Yes.
Q. -- clinical commissioning groups and primary care networks, all to do with primary care?
A. That's right.
LADY HALLETT: In England?
A. In England, sorry, yes. It's really important that pretty much everything I say is about England.
And this programme, we absolutely intended to use primary care and we -- to get through the volume we needed, we needed these large-scale centres.
I should add that the 10 miles became very catchy^^See Louise's note . Obviously, if you're in a city, 10 miles was sort of irrelevant, (cachey ^^)^^here , and later on, when we were looking at low

uptake in areas like Leicester or London, my personal mantra was three bus stops away from somebody who can give you a vaccination. It was a starting point to say that we'd really covered the country. And I was concerned about areas of rurality which look white on the map, like there's not many people there, but there are some people there, and I wanted them to be able to get a vaccination easily too.
Q. Vaccination started in hospital hub sites on the 8th with -- was it Mrs Keenan who was vaccinated?
A. That's right.
Q. And the evidence before the Inquiry suggests that the first GP or at least the majority of the GP vaccinations started on 15 December?
A. That's right.
Q. Did you start with hospital hubs because, in terms of scale, they can deliver more vaccines in a shorter space of time -- and of course this is a numbers game, you've got to get as many vaccines out there in the arms as quickly as you can -- but also the issue of the freezing of the Pfizer vaccine, to which you've already referred?
A. That's right. We did not know until 2 December that we would be able to transport the vaccine at fridge temperature. We thought we would, so my supply chain team was in the negotiations with the two pharmaceutical

grade wholesalers to make sure we could set up that supply chain, but we didn't know. So, given we that six days from that point to the first vaccination, which was agreed with the DAs as well, we needed something that was definitively doable, and that was hospitals.
The second reason was that this was going to be the first vaccination anywhere in the world outside of a clinical trial, and we wanted the -- you know, the infrastructure, the safety sense of a hospital to be the location for that first week of vaccination, so we could keep a really close eye on what was happening.
Q. And at a very high level it's obvious that there was a move away from early centralisation, in terms of yourself and NHS England, producing and making sure the supply chains worked and the vaccines were delivered and the workforce was available and the vaccinations were recorded. And away, at the same time, practically, from hospital hubs and GPs, so primary care networks, to vaccination centres and community points and pop-ups and pods and whatever have you.
Would it have been possible, was it ever possible, to have those more granular, specialised delivery sites, pop-ups, community sites and so on, and mass vaccination centres, available at the beginning?
A. We were -- through November, we were -- we had our foot

on the accelerator of all of the modalities because we wanted to be ready -- not community pharmacy, to be fair, because it wouldn't have had the scale to start off with.

Q. We'll come back to --

A. It clearly wasn't the right place to start. We were equally clear we were going to need it and we were doing commissioning discussions with community pharmacies at the beginning of November. It wasn't that we didn't want it, it's -- wasn't yet. Mass vaccination centres weren't in the running until quite late in November. And then the issue of the freezers, plus one of the core components of the programme that we haven't talked about, which is my focus on operational excellence, because I knew from reading the WHO reports that one way you improve vaccine confidence is by every experience of interacting with the programme is excellent.

And at the middle to the end of November it became clear the national booking system would not be ready for go live until January, so we would have had no way of booking people into a mass vaccine centre. I didn't think that was going to go well. I was really concerned about that.

So we had a barrier which was the supply chain and I think it was better that we waited to launch those

until January.

Also, a third complicating factor showed up, which was that national protocol would not -- wasn't ready until -- around Christmas Eve I think was when it was signed off. And vaccination centres could not have safely vaccinated without the national protocol.

Q. And the national protocol is the document that we'll look at in a moment, and some might say a very prescriptive document --

A. Yes.

Q. -- running to many, many pages, which tells everybody in the vaccine centre what to do?

A. Yes.

Q. Do you assess that what you did, which was to start with hospital hubs and then very shortly thereafter move into primary care networks and GP surgeries, and then move out to vaccination centres and community hubs and the more specific specialised sites, to try to get to every sector of the population, worked, or should we be thinking next time in terms of having mass vaccination centres and specific community sites up and running at the beginning of a vaccination programme?

A. I mean, I think, realistically, it will depend on the nature of the pandemic and of the disease and of the vaccine. What I'm hoping is, partly through the

Inquiry, we'll have that blueprint, and that ability to test, ready to go.

I would say that I think starting in hospitals and GPs, in particular, for the most at-risk groups that we had, which was the elderly people and people in care homes, that primary care was the right model. And if we hadn't been so sure of that, we probably wouldn't have pushed GPs so early the 15th, because of the complexity of the supply chain, et cetera, but we did because that was what our priority cohorts needed.

You mentioned pop-ups. We started really doing pop-ups on 16 December, when we started trialling in care homes. They were their own very special kind of --

Q. They were there for a relatively -- (overspeaking) --

A. -- pop-up, effectively. Yeah.

Q. I wanted to ask you about that, because it's recognised, isn't it, that large hospitals have a poor ability to reach high-priority patients. The very elderly may have accessibility/transport issues, but also genuine concerns, properly held, about fears of infection, vulnerability --

A. Yes.

Q. -- about going to a large hospital. How did you meet those concerns and how did you cope with -- or how did you arrange for early vaccination of vulnerable

high-priority people?

A. So this is where we actually changed tack on 2 December. So we had been developing everything in parallel, because of that concern around supply chain, as I said, that's why we were doing that. But because we became aware again, around -- probably just before 2 December, that we would not have enough vaccine in December from Pfizer to vaccinate all over-eighties, even if we only did them, it became absolutely essential to vaccinate the over-eighties.

What we had planned to do was to start perhaps more with health and social care workers, because they could travel to the vaccine, and we obviously would have started with the over-eighties in GPs the following week. But that became ethically the wrong answer. So we actually pivoted, actually, on 2 December with a webinar that I think I had on the 4th with all of the COOs who were running the hospital centres to say: right, you now need to work with us to figure out how to invite over-eighties into your hospital because that is your priority group.

And we didn't prescribe how they were going to do that. We offered support but we asked them to work with their GPs. A couple often the hospitals used existing booking systems, local booking systems that they had,

but we said: you need to work with your communities to bring the over-eighties in that first week of vaccination.

Q. And I want you, please, to say something about the sheer complexity of this process. And in terms of logistics, there was a very significant problem, wasn't there, with the fact that the Pfizer vaccine couldn't be transported at a higher temperature than freezer temperature for more than a particular amount of time?

A. That's right.

Q. And, indeed, its authorisation required it to have no more than two journeys, I think --

A. Once defrosted, yeah.

Q. -- above a certain temperature?

So a normal, average-sized GP surgery, wouldn't have enough time to split up and use the pizza box of doses within time before it melted and became unusable. So, I mean, there were some incredibly complex issues to be resolved here, weren't there?

A. There were, yeah.

Q. And in terms of the scale-up, give us some idea, please, of the speed with which you scaled up from the 52 hospital hubs on 14 December and 116 local vaccination sites, to the position in the beginning of February?

available, and then delivered to the right person?

A. That's right. And it mattered much more that you'd made an appointment at the right place for the right vaccine on the right day, so the supply chain complexity where, if it's the first dose, at the end of the day if the GP's got vials left over, they had permission to not waste it, to vaccinate the next most sensible person. For a second-dose clinic, it had to be the right people at the right time receiving the right vaccine, so it's a more complex delivery challenge.

Q. And what was the obligation in terms of the time allowed to record in GP's records the fact of vaccination in every individual case?

A. In 24 hours into their record.

Q. And was that something that was required by the MHRA or DHSC or --

A. It's in the national protocol.

Q. It's in the national protocol, the document to which you've referred?

A. Yes.

Q. All right. I just want to now turn, please, to some particularly discrete and individual issues.

On 8 December, two incidents were reported via the Yellow Card system of adverse reactions to vaccination. Was that anaphylaxis?

A. By the beginning of February we had 1,270-something -- I want to say 1,277, but I might have remembered the number wrong --

Q. 1293.

A. Thank you very much. I apologise I didn't get that right, but I've a lot of numbers in my head -- of which the majority were local vaccination services, so a mix of pharmacy and the primary care networks, which we haven't mentioned, but I assume are somewhere in there, which were groups of GPs that had been established earlier, in 2019, to put groups of GPs together at a certain scale. They became the right scale for vaccination.

But that included all hospital -- all of our existing hospitals, so all 256 trusts, including community trusts, for example, were set up by the end of the month in order to vaccinate staff in particular -- by the beginning of February, sorry.

Q. And was an additional problem that the second dose -- and by February, of course, you've got authorisation for not just Pfizer but AstraZeneca?

A. Yes.

Q. The second dose has to be the same as the first dose. Did that then mean that you had to try to put into place a system whereby a second dose would be available, kept

A. Yes.

Q. What happened as a result of the reporting of those two reactions?

A. So those were flagged through the Yellow Card system. I was notified during the day through the mechanisms, and MHRA is the authority that's collecting the pharmacovigilance information and they -- I honestly can't remember who convened the call, but at 11.30 that night there was a call with CMO, June Raine, JVT, myself, Steve Powis, the national medical director, DHSC, so that the CMOs could look at the information, it could be considered -- oh, sorry, I can't remember if Wei Shen was there as well -- to say: was this unusual or was this expected? Anaphylaxis is a serious but not unexpected reaction to a vaccine.

And it was in that call that the decision was made that it was safe to continue the programme, but that we should introduce the 15-minute wait post-vaccination to ensure if something was going to happen, it happened on site, not when somebody was travelling home.

Q. And was that significant tweak to the system put into place from the following day?

A. It was incredibly significant and quite lucky, in a way, that we were still only vaccinating in hospitals, which are large institutions which have space. If we'd been

in GPs, and they were -- which we were only seven days or six days later -- changing the space around would have been much more disruptive for them. As it was, we summoned everybody who was vaccinating to a call at 7.30 the next morning and said, "Right, you're going to need to change your layout, you are going to need to change your staffing model so that somebody can observe", and so on, and obviously we worked with GPs to adjust what they were planning for the following week.

Q. And you'll forgive me for making what may appear to be a very obvious point. So from the time at which the two cases of anaphylaxis were reported to changing the way in which vaccines were delivered on the ground, all took place within 24 hours?

A. That's right.

Q. The workforce. Is this right: the vaccinators were generally organised and trained by part of the NHS, the integrated care system part of the NHS, but you also had available volunteer vaccinators from St John Ambulance?

A. Yes, it's slightly different than that, if I may.

Q. Please.

A. We used the ICSs as the central point of deployment of the workforce.

Q. ICSs?

A. Sorry, integrated care systems. So the 42 semi-local

organisations which oversee the relevant part of the health system and have local relationships with local government, public health, et cetera, and social care. We wanted workforce to be deployed locally. We were not sure at the beginning whether that would give us sufficient scale. Whether there would be enough people in it, and also you might have some places with not enough people. And so we also put in place the national offer with the support of St John Ambulance and the Royal Voluntary Service.

The training was done nationally. That was developed by PHE and Health Education England, and it was all done online, and depending on your level of qualification, you had to do different modules of that to be qualified as a vaccinator.

Q. And to be clear, anybody who vaccinated, so that is somebody within a GP surgery, or anybody within the primary care network, which is a combination of GP surgeries, anybody in a pharmacy or in a hospital or a mass vaccination centre, or a community hub --

A. Yes.

Q. -- had to be trained according to a protocol?

A. Yes. And if they were not previously experienced vaccinators, they also had a period of observation and senior supervision to make sure they weren't just

trained; they were actually confident in what they were doing.

Q. So it wasn't enough to be a doctor or a nurse or a clinician; if you were vaccinating, there was additional training?

A. That's right.

Q. Because the material before the Inquiry shows that some people have expressed concerns about the comprehensive nature of the training and the degree to which you did train vaccinators, were vaccinators trained in all aspects of the vaccination? So, not just clinically how to deliver a vaccine into an arm, but in relation to the reporting of the vaccine, the reporting structure, as well as, importantly, safety and the possibility of adverse effects?

A. Yes, there were multiple modules, and I believe, although I'd have to add them all up again, but the majority of the modules were specific to this vaccine and the nature of how you dispensed and delivered this vaccine safely, the specific potential adverse reactions for this vaccine.

Q. Let's have look at the protocol to which you've referred. It's the national -- this one is for Pfizer, because it's Comirnaty.

But it's INQ000486279 dated 20 November. There we

are. Pfizer. Valid from 20 November 2021. So is this, essentially, the training document for the handling and the delivery of and the vaccination of this vaccine?

A. It's one of them. It's not the training material but it comprises everything somebody is going to need to be able to do it safely.

Q. They're told to do what's in this protocol.

A. They are, yes.

Q. All right. And we can just, if we could just scroll thorough very quickly from page 7 onwards, "Characteristics of staff". So there were operational stages of activity to do with vaccine preparation, administration, recording keeping, and this prescribed whether registered or unregistered healthcare professionals could carry them out; is that right?

A. Yes.

Q. Then you've got at the bottom of the page, protocol stages. Over the page at page 8, the degree to which they had to have pre-existing training on top of this training in order to be able to carry out certain parts of the vaccination process.

A. Yes.

Q. Over the page to 9. Detailed prescriptive rules concerning assessing the patient who was presenting for vaccination.

A. Yes.
Q. Over to page 10. Cautions. So very detailed rules concerning the identification of conditions and reactions in the patient, everything from fainting to reactogenetic (sic) side effects, you know, reddening of the arm, and so on. And then "Very rare reports have been received of Guillain-Barré syndrome" in the middle of the page.
Past history of Covid infection, that's 10.
Then we can, if we just scroll through 11, 12, 13, 14, through to 19, rules on dose, frequency of administration, action to be taken if the individual is excluded, description of treatment, drug interactions, off-label use, adverse reactions, advice, follow-up treatment, special considerations, and finally on page 19, non-responders/immunosuppressed.
Do you consider, Dame Emily, that there was any deficiency in the training processes -- obviously you're not physically present in every single training site, but in the general obligation for training, and the degree in which that training was prescribed?
A. I don't have any concerns about it and I know it was robust in that one senior clinician notified me that he'd failed the competency assessment the first time around because it was so long since he'd last vaccinated

and he had to do it again, and he was fine with that. He said, "It's the right thing to do, I want to make sure I can do it properly."
Q. Was he really fine?
A. I don't know but he told me about it, didn't he? And he did then go on to vaccinate.
Q. The NHS England operated a National Immunisation Management Service database called NIMS --
A. Yes.
Q. -- into which data from another system, NIVS, was placed, along with data from a GP data system called Pinnacle?
A. Yes.
Q. Do you think that the database which -- the databases which you used were sufficient and effective in terms of trying to exclude too many overlapping and overly-complex databases?
A. Having been through it at the time and then gone back through my weekly reports from the tech team from November through to about April in preparation for this, I am sure that we developed something that worked in terms of keeping people safe, making sure there was a record of their vaccination, just in case something happened, that worked for us to record that we were safely delivering the vaccine, that we were able to

check up on site to make sure they were using the vaccine they got. It did what it needed to do.
It was complex, because the architecture of various different health system, IT systems, which I'm assuming we don't want to go into, is really complex, and there was definitely a gap, which we may come back to, in terms of ethnicity and other data about individuals, which is not held as standard in those systems.
Q. The issue of health data generally is extremely complex.
A. Yes.
Q. And it was in fact the subject of a review, as I know you know, by Professor Cathie Sudlow in November 2024.
A. Yes.
Q. So last year. And we'll come back to that at the end. But the problem, in essence, is this, isn't it: that there are systems operated by GPs which carry codes, SNOMED codes, that's to say medical characteristics of the patient, but those records are not always as up to date or perhaps as accurate as they might be, and at the same time, there's no GP or general NHS system which includes occupational data, what your work is or what your job is, and also ethnicity? So there's no general obligation to record ethnicity, either at the point of access to NHS services or at the point of recording a vaccination.

So did that make it extremely difficult, when you were asked how can you best reach out into the community, for example, amongst ethnic minority communities, and see what we can do to encourage take-up? You didn't know precisely what degree of ethnic take-up there was of vaccination?
A. We didn't have entirely robust data at least initially. It got better as it went on, which we can come back to. Actually, many GPs, not all, had some ethnicity data recorded. It was inconsistent but it wasn't zero. And indeed, we can come back to this, but some GPs did also have a record of whether somebody was a carer or not. As you say, it wasn't mandated. But NHS England had, to some extent, looked ahead at this and already in September 2020 had written to all GPs to say, "Please can you review your holding of this kind of data," not carers, actually, but ethnicity data, and where you've got it, can you make sure it's updated into systems, partly as a reaction to some of the initial events of the pandemic before we got to vaccination.
So we were working on it, but you're right, it wasn't complete.
Q. But was that letter in part why the process got better and you managed to get better data over time?
A. We managed to get better data over time partly because

we then also started, I think towards the end of January, not because we didn't want to do it sooner but because it took that time to engineer it into the systems asking for ethnicity data at the point of vaccination.

Q. In sites?

A. In sites, which we hadn't done initially for reasons we can come back to. But what we were able to do through using Foundry, what -- the Palantir product, what that is particularly good at, is taking different datasets and then using the characteristics of those datasets to put it together, and say, "This is almost certainly the same person." So we were looking at cuts of ethnicity data already, certainly towards the end of December. It just wasn't complete, and I couldn't absolutely put my hand on my heart and say we had everybody, but we had indications relatively early on that.

Q. So in essence, the structure is there, but it's patchy in terms of --

A. Yes.

Q. -- of its output?

I will ask you now about Professor Cathie Sudlow's review of 8 November 2024, the health data review.

Amongst the five recommendations that she makes, there are two of particular relevance here. She

suggests that key government healthcare and research bodies should establish a national health data service in England with accountable senior leadership and also that national health data organisations and statistical authorities in the four nations should develop a UK-wide system for standards, ie --

A. Yeah.

Q. -- not overly prescriptively demanding that there be a national data system across the whole of the United Kingdom, but at least agreeing a standard so that each nation can have compatible and sufficiently proper standards for -- especially proper data systems.

I'm sure you have something to say about Professor Cathie's review. Do you endorse those particular recommendations in the context of trying to roll out a vaccination programme in the future?

A. The shorter answer is yes. If I might just elaborate for a second.

Q. Please.

A. The second one, I don't think anybody would argue with, and indeed, the issue of people who were vaccinated in an English centre but had a Welsh NHS number went on for a while before we could solve it and vice versa. So absolutely, having agreements about how we do that and consistent data would be hugely valuable for public

health as much as for anything else.

The work I am engaged in and sponsoring at the moment is to try to get, most particularly, to a single patient record in stages. I think it is -- it would be of huge benefit to the patients. And the thing I didn't -- I absolutely endorse Dr Sudlow's report. The criticality here is it's integrated for the patient. You mentioned SNOMED codes. The reason SNOMED codes are not always current is because somebody in secondary care --

Q. Is inputting them.

A. -- issues, you know, a clinical decision. That is then sent to the GP who has to then update the primary care record. Some systems have integrated the records, but by no means all.

So from a personal user perspective, you want every clinician you meet to be able to understand what's going on with you, and that isn't always the case. And that would be the biggest advantage, I think, to the individual.

Q. The precise medical condition from which the patient -- for which the patient has presented himself or herself --

A. Yes.

Q. -- needs to be recorded, along with --

A. Along with everything else, yeah.

Q. -- ethnicity, occupation, if any, so that when you dig into the data system for the purposes of deciding who needs to be offered a vaccination, who needs to be approached to be encouraged to take it up and who gets it, you have got it all, as you say, in a single point.

A. In a single point, and because that person then has a better experience of care. The thing, I think, that is important that we consider as we go along, which Dr Sudlow does talk about, is we have to bring people with us, right, because for -- at least -- not -- there is a general acceptance in the UK that this would be a good thing, people are happy for their health data to be used to make their lives and their care better but there is that level of distrust about what your data is being used for, particularly in some communities. What I wouldn't want is for people not to come with us on that journey and feel that their data is going to be used for purposes that they don't consent to and I think we have to do that work at the same time.

Q. Thank you, that's very clear.

There came a time when the decision was made to move to a 12-week second dose cycle --

A. Yes.

Q. -- for Pfizer and AstraZeneca., and we've heard evidence

as to why that was so. Did that present itself as an extraordinarily complex shift in position, as far as you were concerned, in terms as changes in supply allocations, the bookings, the workforce arrangements, and what to do about people who had already agreed a second appointment?

A. Yes.

Q. All right. You were able, within a relatively short space of time, to completely change the direction of the system?

A. Yes.

Q. There were, in the press and elsewhere, and in political circles, from time to time, criticism of the rates of vaccination. Did you produce a bar chart which showed the levels of delivery which you were planning for and hoping to achieve against actual delivery?

A. Yes.

Q. Can we have your statement, please, INQ000492335. Thank you very much. There it is.

We can see there that, as at 19 January, so within, really, a very short space of time after the first vaccine delivery, you had planned for and promised a certain level of delivery. Did you meet that plan and get the number of actual doses out that you'd promised you would?

A. In general we did, I believe. If we looked at this from a month later, there were some weeks where we were within shooting distance but not exactly on the number, which always pained me. And it was obviously subject to supply fluctuations which did happen over the -- towards the right-hand side of this chart.

Q. Presumably you received updates hourly or at regular intervals during the course of every single day as to the rate of vaccination?

A. Yes.

Q. You must have pored over the charts and the figures --

A. Yes.

Q. -- the whole time?

A. I had a dashboard which was always open on my desk.

Q. And presumably you made available to the public and to the rest of government update figures on levels of vaccination?

A. Yes.

Q. Daily, weekly, fortnightly?

A. It changed. It started off with a weekly publication. It moved to daily on 11 January, a Monday. And over time, we then did an automated feed straight into the Cabinet Office of certain metrics, so that we weren't providing the report, they were getting automatic data updates. And then there were other data sharing

agreements with other parts of government.

Q. You mentioned the national booking system earlier.

A. Yes.

Q. It started, I think, on 9 January. That was its full operational launch. Why was it not possible to have in place a national booking system at the point of the commencement of the vaccination programme on 8 December?

A. I mean, partly we didn't think it would be required earlier. Secondly, this was being built from scratch, building off of these incredibly complex systems that don't talk to each other that we've already described. And it needed to be simple, it needed to be incredibly user friendly, and it needed to work as a front end, and then it needed to be pulling data from these multiple sites about what actual availability they had, which they had to plan based on what supply we were sending them and what workforce they had. So this was the system that was going to have to be the front end to a lot of complexity underneath the surface.

I was very keen, as I've described earlier, that we didn't launch it until we knew it was going to work. And --

Q. Because in terms of confidence --

A. In terms of confidence --

Q. -- collapsed system is disastrous --

A. And also being offered a vaccine booking 100 miles away from where you lived was just not going to be good for the programme. It was going to look like it wasn't accessible, that we hadn't thought about the location. So we had to work very carefully to put the right wrapper around that. And despite pushing very hard, my tech lead, Adrian Stanbury, who started at the beginning of November, came to me -- I think it was probably like, the third week of November, and said, "Look, it just isn't -- I can't push it that hard."

It also had to be clinically safe, there was a clinical sign-off process as well. So there was a bunch of stuff to engineer into it.

Q. Is there a national booking service for routine or childhood immunisation?

A. There wasn't one, no.

Q. So, ordinarily, one would have to wait to receive a letter or a text saying, "You are being invited to come in for vaccination or immunisation"?

A. Yes. So the school vaccination of flu, for example, which my son gets, that's how you get it. The Red Book vaccinations, the ones that happen in early childhood, tend to be done through routine appointments, where people are going to their health visitor or GP anyway, but if people don't come, then, yes, they would get an

invitation that way.
Q. There was no online ability before 9 January 2021 for anybody to go to an online site and book themselves an immunisation or vaccination?
A. Certainly not from a national perspective. Individual local systems may have had something I'm not aware of.
Q. All right. Relationships with devolved administrations. Did the vaccinations commence on the same day in each country?
A. Yes, for both the first Pfizer dose and the first AstraZeneca dose, on 4 January.
Q. Was there a close degree of cooperation between yourself and your fellow SROs in the other three nations?
A. Yes, very much.
Q. So did the SROs join critical meetings held by the NHS England as well as UK governmental meetings?
A. Yes, so they were all invited to my operations board, which used to happen every Monday morning, just so they could stay in tune with what we were doing, and challenge it if necessary.
Q. Public health is a devolved issue.
A. Yes.
Q. So it was absolutely within the ability and the right of each nation to decide for itself how to deploy vaccines?
A. Yes.

Q. At what point did each nation take over the deployment process? Was it from the arrival of vaccines within the geographical confines of the United Kingdom or was it from the point at which they were delivered to Public Health England warehouses, or what?
A. So, for England, it was from the PHE warehouse. I think that was -- I'm trying to remember. I think that for -- in a couple of instances there was direct vaccine --
Q. Delivery --
A. -- supply into one of the countries, but I can't now remember -- I remember the discussion around this, but we --
Q. Broadly, the taskforce --
A. We took over from PHE, yeah.
Q. The taskforce organised procurement --
A. Yeah.
Q. -- and delivery into the United Kingdom --
A. Into the PHE warehouse, yeah.
Q. -- but there came a point where, physically, each nation would take over --
A. Yes.
Q. -- what happened but to the vaccines thereafter.
How important was it that even if you weren't in lockstep, each of the four nations broadly agreed on how the vaccine delivery would be prioritised, and

physically made available?
A. I think it was incredibly important for public confidence. I mean, we're not -- well, I don't want to get into a political statement, but -- we are the UK, it was the -- the VTF was operating on behalf of the UK. The countries he had made a decision to buy vaccine together. It was important that the citizens of each country had a similar if not exactly the same experience of being vaccinated or being offered a vaccination.
Q. You obviously spoke the whole time to your fellow SROs, and you WhatsApped each other frequently.
Can we just have INQ000477804, at page 22, please.
This is an example of your communications. It happens to be 22 February in the early afternoon, where Naresh Chada from Northern Ireland -- Dr Chada says:
"We're having a bad day at the office today. Unpaid carers."
Derek Grieve from Scotland:
"Been there got the T shirt."
Gillian Richardson, from Wales:
"Yes agree Derek."
Emily Lawson:
"We are also using broader definition as ..."
People?
A. Yes.

Q. "... ppl with carer designation from [Department for Work and Pensions] are more than jcvi."
So in relation to almost every aspect of how to apply prioritisation in practice, how to broaden it out operationally, as well as the physical and technological aspects of getting vaccines into everybody's arms, was debated daily between you all?
A. Yes.
Q. I don't think we need to spend a great deal of time on it but no doubt there were times of turbulence where you disagreed on particular aspects.
By and large, were those points of turbulence induced by events in the media or communications or public sphere, particularly the political sphere, where somebody would say something and then you'd all have to speak to each other and go, "Well, he didn't really mean that", "She said this out of turn", "This the real position"?
A. Yes.
Q. All right. By and large, do you think that process of communication between yourselves worked very well?
A. I think it was incredibly helpful, in the sense we were all in it together, rapid testing of things that were going right or going wrong, and then coming back together formally each week to make actual policy

decisions supported by the Department of Health in our weekly DA-SRO meeting.

Q. Now, just even more briefly, a handful of remaining areas. In relation to digital exclusion, there's been a great deal of evidence before the Inquiry as to how GP records were critical in inviting people to vaccination, but there are gaps in the data.

A. Yes.

Q. There are gaps in relation to Home Office data on asylum seekers and refugees, there's gaps in local authority data on those sleeping rough, homeless, and those in accommodation, and also a lack of data for Gypsy, Traveller and Roma groups.

How did you get around those obvious and well-known problems with being able to identify reasonably everybody in each community?

A. So, to start off with, the NHS number was pretty foundational, not necessarily registration with GPs. So if you look at the enhanced service agreement with GPs, in -- even in its first version in, I think it was, first week of December, might have been the last week of November, it specifically says GPs are on the hook to vaccinate unregistered people, so we were conscious of that. And we did do work to try to get more people to register to overcome that, because obviously it's an

opportunity to get people more engaged in healthcare. The real challenge was not having an NHS number.

Q. Why does not having an NHS number matter so much?

A. Because it is the link to the records that we hold on you, so it is a critical safety issue in that it means somebody can check, you know, what other treatments you've had, for example, and whether you have a risk of, you know, bleeding, for example.

Q. So you don't need an NHS number to get a vaccine, you could turn up at a mass vaccine centre, but in order to be able to bring yourself to the attention of the state so that it knows whether or not you need extra assistance or extra help or whether you need to be, to use an expression we don't really use any more, "reached out to", you need to have that data, and the data is going to be by and large in the NHS system. Without a registration or a number it's not there?

A. Yes, and you don't have to be registered with a GP to have an NHS number. If you've ever shown up to a hospital you will have been given one. The issue was our systems were built around people having an NHS number. So check-in at a hospital centre NIVS required an NHS hospital number. We made it easy to find it. You could do an immediate look-up. We didn't want you to not get a vaccine, so we knew from the beginning we

were going to need a workaround for people who didn't have an NHS number, but also required to use the NBS to start off with, and so by -- I'm not going to get this completely right but it's on our list of tech issues from early December and by the time we get to the end of January, we've agreed a workaround that is clinically agreed for the safety reason that you've just articulated, but that will actually be designed into our system so that we could systematically vaccinate people who didn't have an NHS number, although we would obviously encourage people to register, as part of the vaccination programme, and communicating that became very important to -- particularly to -- less so to Gypsy, Roma and Traveller where more the engagement and finding them sites that were convenient and often taking a vaccine to them was critical like going to Appleby Horse Fair, for example, but for migrant groups, some of whom were very concerned about how their information would be used, being able to be vaccinated by that one was actually essential and the best example of that was a pop-up that the London team did in Soho in, relatively late, sometime in June, I think, specifically advertised as "You don't need an NHS number" and it had 2,000 people show up.

So there was that pent-up need. It took us a while

to design it into the systems.

Q. Presumably as the national director, you couldn't know and you weren't told of specific problems in accessibility in individual sites, in particular, for example, for disabled people. But did you put into place systems by which you hoped that the majority of accessibility issues would be tackled and addressed and dealt with?

A. Yes, the service -- the specifications for any vaccination centre said that they needed to be accessible, and the information about what accessibility was offered was built into the NBS so people should have been able to --

Q. Into the?

A. Sorry, the National Booking Service. So it said what that centre had, including what translation was available, for example.

Q. And of course, there will always be gaps. There may be individual sites --

A. Yeah.

Q. -- where things didn't work as well as you wished. Was there a standard, an NHS or UK Government standard which was applied in terms of what the vaccination centres had to do in terms of making themselves accessible to, in particular --

A. Yes.
Q. -- disabled people?
A. Yes, there was.
Q. And was that adhered to, at least systemically?
A. I mean, as far as I knew, and it was certainly -- it was part of the sign-off that the regional directors of commissioning did when they agreed to a site going live was that those conditions had been met.
Q. In general terms, in relation to addressing disparities in uptake, is it ever possible to deliver healthcare services to everyone who needs them?
A. The short answer to that is no, because we're dealing with societal inequalities which are not under the control of the health service. So we have to do everything we can to come to where people are and design services that work for them, including vaccination.
Q. More specifically, in relation to vaccines which are being offered prophylactically, ie to people who aren't ill already, is it ever possible to reach a hundred per cent uptake?
A. Not in every segment of the population for every vaccination. We got pretty close to a hundred per cent in the cohorts that felt most at risk, I would say.
Q. The uptake in England for two doses for over 12-year-olds by 30 June 2022 was 83.7%?

A. Yes.
Q. Do you think that was a credible outcome?
A. I think it was a credible outcome, given the original planning assumptions, before I took over, had been 75% uptake not including children. It doesn't mean that I think there wasn't more we could do. There's always more you can do but I think it was a good outcome.
Q. At every administrative or political level, was the issue of disparities in uptake appreciated, acknowledged, and sought to be dealt with?
A. Very much so. It was -- I had an equalities team, they were on my leadership team, they were in every discussion. We established the vaccine equalities board which met before we had the vaccine on 1 December and ongoing. When I go back to even before I joined the programme, the programme was engaging, for example, with the British Islamic Medical Association in October to ask about, you know, what would need to be true for people to be able to support the vaccine. So I mean, I won't give you a list because it's in the witness statement.
Q. It is.
A. But it was ongoing engagement and feedback to see what could we do to keep improving.
Q. Could you look, please, at INQ000063195, page 2. This

is a readout, to use the governmental word, or a list of actions from a meeting with the Prime Minister, dated 12 January 2021?
A. Yes.
Q. "The [Prime Minister] asked what is being done to access the harder to reach communities/people, and what more can be done. He asked that the NHS work closely with the [Ministry of Housing]" --
LADY HALLETT: Communities.
MR KEITH: "[Communities -- thank you -- and Local Government]" --
LADY HALLETT: They will keep changing their names.
MR KEITH: Yes.
"... and local authorities -- thank you -- to provide them with everything they need to maximise rollout and uptake ..."
Then there's a reference to Simon Stevens of the NHS.
The Prime Minister pressed for data to be made available as soon as possible. The Health Secretary referred to the approach to being able to address disparities in uptake, and the Prime Minister then asked the CMO for his view on the relationship between NHS and the local authorities.
Was there any doubt in your mind, that the issue of

how to address barriers in uptake in pre-existing disparities, particularly in healthcare, were being addressed at every turn?
A. I think on 12 January I would say it was absolutely top of mind. We were holding regular meetings on it. In terms of taking some of the really good example like the one that is cited here in Dorset and scaling them, there was -- we were in the early foothills of doing that and I think what really changed over the -- we did, by the way, make sure that the data was shared by -- we started the full-on data sharing on 15 January, so just at the end of that week. What we were able to do, starting around this time because we weren't so limited by the supply of vaccine and because we had AstraZeneca that was more stable, easier to distribute, came in smaller packages to start off with, just the creativity that local systems could apply to outreach started to really take off.
Q. Right.
A. And because a lot of the outreach and, sort of, small-scale it takes a lot of people to deliver one vaccine was being used in care homes at this point and then we get towards the end of January and most of that work is completed, most care homes have now had at least one visit, there's then more capacity to do further

engagement and outreach --
Q. -- to focus on specific communities?
A. Yes. Plus communities started to come forward more. If you -- you may not remember, but the conversation publicly about the vaccine programme over Christmas and into the New Year wasn't great. It was kind of going to be another example of failure. By the time -- we've shown how much ramp-up you saw in that chart you showed earlier, by the time you get to certainly the third week of January, it's like, oh, this actually might be a success and that encouraged lots of people to say, "I want to help, I want to come forward, I've got this idea" and so we have, for example, the first mosque as a vaccination centre opening, I think on 21 January, the Crawley Bus, which was a local initiative, didn't come from me, at the Hindu temple there, was on 28 January. So just that local engagement and creativity starts to really take off at this point.
Q. And presumably there were a number of plans and actions put into place to generally increase uptake and to encourage people to come forward. I think Grab-a-Jab, was that one of yours?
A. Yeah, Grab-a-Jab came from us and was actually carried out by my Chief of Staff, Ellen Graham who put the whole -- well, corralled, putting the website together over

a weekend in May. Grab-a-Jab was a good example of adjusting to a new cohort. So we now had -- because we'd vaccinated down to, sort of, age 50 by the beginning of April so we were now vaccinating those in their thirties and forties, and they had really different needs from vaccination centres. They were less bothered about appointments, they needed more out of working hours, et cetera. And so Grab-a-Jab was an example of: you're just spontaneously going to decide to have a vaccine this weekend, here's where you can go, and made it more of a social activity, partly because lockdown was ending so we needed to make it even easier for people to get a vaccine because that sense of urgency when you can't see anyone had slightly started to dissipate.
Q. Let's look, please, at the vaccine uptake plan, this version is 5 February 2021 so around that time. INQ000830899. Did this plan have a number of iterations?
A. Yes, absolutely.
Q. If we look at page 3, we can see statistics as at 3 February. The proportion of people aged 80 plus who have had their first dose by ethnic group and deprivation. So may we take it from this, and the fact that this is in your core vaccine uptake plan, that you

were constantly looking at percentages of uptake across different communities?
A. Yes.
Q. And there isn't, we note, any reference here to Gypsy, Roma or Traveller. Would we find figures specifically relating to them specifically anywhere in the NHSE documentation?
A. No, because it wasn't at the time in the -- what's the right word -- the definitions of how ethnicity data was collected. That's in the process of being updated at the moment.
Q. So how would you know what the level of uptake was in that community?
A. We wouldn't have known nationally. It was the kind of thing that we asked local systems to report to us on, those that had local Gypsy, Roma and Traveller populations, we asked for sitrep information to say how that was working.
Q. And did you get it?
A. Yes, we would -- I would -- not at a level I'd want to report in national statistics, I don't think the national statistician would think it was robust, but it gave us an indication of the kind of thing that was happening, partly so we could share that with systems that were perhaps further behind.

Q. Sorry, do continue.
A. It was just -- the particular paragraph that you pulled out earlier didn't mention this, but this chart is very good on it. There were real challenges, obviously, with different groups not feeling confident to have a vaccine or not finding our offer convenient at the time, but what this chart shows really clearly on the left-hand side is that there was also an intersection with deprivation, that the more deprived you were, the less likely you were to receive a -- to want a vaccine at this point, even in the white British group at the top, it's lower on the left than it is on the right. So we were conscious of that in terms of where we put the next wave of vaccination sites, for example.
Q. Page 5, there are references to the work under way, the actions for removing barriers to access and for improving take-up. Presumably these are very broad descriptions, headlines only, of what was actually being done, but we can see reference to resources, funding options, working with national partners, videos, roundtables, communication material, and so on.
A. Yes.
Q. In your team, were equality and health -- inequality impact assessments carried out?
A. Yes.

Q. What were they?
A. They were sort of a policy assessment to make sure that: if you put this in place, you're not going to -- you've properly considered the equalities impact and hopefully made it more positive not more negative.
Q. And was there something called a vaccine equalities mapping tool to investigate the links in data between locations and take-up, and a Vaccine Equalities Committee to try to guide you as to how you could best improve take-up?
A. Yes.
Q. It's clear that a lot of the work had to be done at local level. So engagement with local community leaders, developing a network of trusted voices, local media and social activity, local ground interventions from Vaxi Taxis, Hopper buses --
A. Yes.
Q. -- clinics in churches and other faith buildings, and social venues.

Who in practice was at the local authority end of all that planning and work? Was it the local authorities, the administrative structures there? Was it directors of public health? And how did work in practice?
A. I would say it was a real mix. So quite a lot of those

initiatives built on existing relationships and outreach that was going on even before the pandemic. So the particular strength in the south-west, for example, where we got a lot of innovation, was because they'd been doing such strong health inclusion work for a really long time. So it might have come from -- it often came from the voluntary sector, so from specialist groups like Groundswell, for example, on the homeless, because they knew what was needed by their groups, and they would either engage locally with people they already knew, often, in that case, the local authority, or it might come -- and those local initiatives, as you say, were critical.

We did also get some national approaches. So the Bangladesh Caterers Association approached my team directly to say, in the Bangladeshi community, almost everybody is connected to somebody in a restaurant, so why don't --
Q. So you arranged vaccinations in restaurants?
A. Yeah, so why don't we -- and they -- you know, we provided support, but they cracked on and did it. They spoke to their own community, and one of the big successes of this is -- you've just looked at the data from 3 February -- between 7 February and 7 April, the uptake in Bangladeshi communities went -- increased

fivefold, just in two months. Which showed that if we found the right engagement and the right ownership in the local community, and individual communities, it made all the difference.
Q. Your statement shows that NHS England published videos featuring people with learning disabilities and autistic people.
A. Yes.
Q. And the evidence before the tribunal (sic) shows that there were a number of projects endeavouring to focus on increasing awareness of vaccination amongst disabled groups, and also trying to overcome the obvious problems of accessibility.

One of the problems that appears to have arisen, however, is that no one appears to have been quite clear who should be offered a vaccine on account of the fact that they suffered from a learning disability, because there was a lack of data as to -- well, the systems for reporting -- the registers for reporting learning disability were not entirely accurate, and no one appears to be quite clear as to what degree of learning disability one would have to suffer before one would even get onto the register.

Was that problem circumnavigated in the end or was it a constant running issue?

A. Can I say both, in answer to that?

I mean, we were lucky in England that we had a Learning Disability Register to start off with. I don't think that was the case in all of the DAs, but -- so we had a starting point. And it was one of the things, again, that NHS England wrote to Systems about in the autumn of 2020 to say: please can you make sure you're updating this, because -- partly, again, because of the increased morbidity and mortality among people with learning disabilities earlier in the pandemic. So we had a start.

We did a huge amount of engagement with clinicians and with communities on the SNOMED codes as we went into cohort 6, because there were potentially thousands of these individual classifications that needed to be included --
Q. And they -- in general terms, they were meant to be, and were anticipated to be, within cohort 4 and cohort 6, depending on --
A. Yes, depending on --
Q. -- degree of --
A. Yes. And indeed Down's syndrome moved from cohort 6 to cohort 4 because further data on morbidity came through.

So we did all of the engagement. I absolutely will say that, you know, that we had the complete register to

start with, we'd have been in a better position, but I think we both had a decent starting position and we worked really hard to improve it, and we tried to build into that what would really work for the people that we -- that were -- needed to receive the vaccine.

Q. Then, finally, you've taken the care to set out in your statement lessons learnt and some recommendations.

We've discussed briefly the nature of the NHS system, its branding, its unitary nature and its systems. You appealed to, or you extol the virtues of working together, asking for help and receiving it, being well funded, and also being able to have access to and being able to use proper, accurate, up-to-date data.

A. Yeah.

Q. All of which are laudable but quite general appeals, or recommendations.

Have you seen the expert report prepared by Dr Kasstan-Dabush and Dr Chantler on the issue of deliveries?

A. Yes.

Q. I just want to read out and summarise six of the recommendations they make and I just wanted to ask you whether you agree:

The keys in future are closing gaps in routine programme delivery by addressing more aggressively

barriers to access.

Having national communication campaigns reaching out into groups, particularly ethnic minority groups, but any groups where there are high degrees of vaccine hesitancy, between pandemics.

Long-running and entrenched inequalities need to be tackled between emergencies by using local place-based partnerships.

There needs to be better identification of priority of risk groups, for example people with conditions that are not recorded in patient notes, Learning Disability Register, for example, or unpaid carers.

An expanded vaccination force ready to go, consisting, perhaps, of health visitors or through having already-trained primary care teams.

And lastly, although I'm not expecting you to comment on this one, the importance of instilling and maintaining high levels of public trust in government, because of the flouting of public health rules by government tents to undermine confidence generally.

With the exception of that last one, which I'm not going to put you in the awkward position of answering, would you agree with those general appeals by our two experts?

A. I absolutely agree with the direction of those, and it's

an incredibly detailed report. I think, considering that alongside Dr Larson's report as well, looking at hesitancy is really helpful.

I think, for some of them, it's worth thinking about how they would be operationalised. I mean, we are not short of vaccinators day to day for doing the routine activity. So one of the things I -- just as one example, what I tried to reflect in that closing bit of my personal statement is I recognise it's really hard to spend taxpayer money on things that you don't need at the moment. So I think there is an element of -- for the Treasury and the government, rather than for me, to think about: (a) is there something it can be doing now that then enables it to do something different in a pandemic? And secondly, what level of resilience do you want to build into obviously not just the health service, but more broadly? And that's a really difficult decision.

Q. You have no trouble at the moment, do you, for finding enough vaccinators for routine vaccination?

A. No.

Q. And the evidence shows you scaled up a huge number of vaccinators to deal with Covid?

A. We did. And most -- some of those were volunteers, but in fact we underused volunteers, right? The -- sorry,

lots of people volunteered we didn't end up using because we didn't need them.

So I think, for me, the point from -- more broadly from the pandemic on this, rather -- this particular issue, rather than just for vaccination, is the energy that local communities had to get together and help the community, partly in vaccination, partly in other parts. The volunteers early on for people who are housebound, for example, which my dad benefited from.

There feels to me there's something there about more broadly how do we use volunteers, how do we capture that spirit of actually wanting to help? And that might have more sort of extended use rather than just for vaccinators and --

Q. Do you think there was enough use of health visitors and pharmacies?

A. Health visitors, I haven't looked into in detail. So I think everybody was mobilised locally who wanted to help. Whether we could have used more of the health visitor expertise, I'm not sure, perhaps, particularly with -- with particular parts of the population.

Pharmacies, as I said, we didn't start in pharmacy for scale and complexity reasons, but we really used pharmacy. By the end of the relevant period there was -- just under 21% of the Covid vaccines were

delivered in pharmacy, so they kept going. And in the recent campaign, the winter campaign for flu and Covid, they did over 40% of the Covid vaccination, so the role that pharmacy plays in vaccination, particularly in areas of -- which are underserved by both primary and secondary care is absolutely vital.

There is one other one I just wanted to quickly react to, which was the communications one. I think national messaging was really important, I think there were some really powerful campaigns, but for people who are not inclined to trust government or, you know, big organisations, actually trusted voices, somebody you know or somebody who has similar background to you, who is speaking in a different language perhaps, preferably who is also clinically qualified -- it's quite specific -- but trusted voices were that much more powerful when people were already concerned, and I think we should make sure that's part of that overall, sort of, broadcast strategy. Some messages are better delivered in a quiet conversation that maybe doesn't end up with vaccination but does end up with you feeling more confident overall. And those 3Cs of confidence, complacency and convenience that were built into every part of the programme, I think they're very well reflected in the expert report, which is brilliant.

MR KEITH: Thank you very much.

LADY HALLETT: Thank you, Mr Keith.

Ms Douglas, I think you have a few questions.

Questions from MS DOUGLAS

MS DOUGLAS: Thank you.

Can you hear me okay, Dame Emily?

A. Yes.

Q. Thank you. I act on behalf of Clinically Vulnerable Families who act in the interests of the clinically vulnerable, the extremely clinically vulnerable and the immunosuppressed, and I have just one question and it relates to models of vaccine delivery. We've heard your evidence earlier about the efforts made to get the vaccine to over-80-year-olds and people in care homes in the early weeks of the rollout, and you've described, at paragraph 202 of your statement, the steps taken by NHS England to ensure that certain housebound and disabled patients were able to receive the vaccine.

Many CVF members in fact had to travel significant distances to vaccination centres, and a pressing concern, particularly for those who had been shielding up until then, was the risk of contracting Covid-19 associated from travelling to be vaccinated, either from public transport or when being driven by someone in the close confines of a car. CVF's members also report

safety concerns about some vaccination centres, for example them being very crowded with poor ventilation.

Given the particular issues for clinically vulnerable people who were being asked to travel long distances, why were strategies not developed for delivering the vaccine at home to these high-risk groups who may not necessarily have been housebound or physically disabled?

A. Thank you. So I hope it is clear from other parts of the statement and from the service specifications for all the different modalities that the centres being safe was a really critical part of delivery and they were expected to uphold, at the time, masking and social distancing. And that as I said, that would have been part of the sign-off process that they were doing that. It's equally clear from the individual experiences you're recounting that that wasn't everybody's experience which is obviously, you know, incredibly disappointing.

I would have expected those kind of issues to be reported in the local system and then managed locally, and if they were consistent, then to have come back to me and don't recall them coming back to us nationally. A few individual complaints did, but not those kind.

So that doesn't make it, you know, okay for the

people that experienced that but I don't think it was a wide problem. I think centres were very conscious of being careful about social distancing and I remember one example in Newcastle where they had people queueing outside in the snow, which also worried me because people had come too early for their vaccination, so I think we had lots of different needs that were being juggled operationally. It was part of the system and it was part of the oversight, the safety of the site.

You also talked about travel. We expected clinically extremely vulnerable, so I think we're particularly talking about cohort 4 rather than cohort 6, let's say, yes, that they would largely be vaccinated by their GP because their GP was holding the Shielding List, and indeed local authorities would have been also aware of who they were.

So that should have dealt with some of the local travel issues and I would have expected their GP to be close to them. It may well be that in a few places the local PCN perhaps wasn't vaccinating at the time. We would have always wanted to work to make it convenient.

The definition of housebound was a clinical definition that the programme itself didn't develop. It was important to limit it, though, operationally because obviously it was incredibly low volume so we -- given

that we needed to reach a whole cohort nationally, we had to balance individual needs with the local population needs. I thought we struck the right balance but clearly for a few individuals that didn't manifest.

LADY HALLETT: Thank you, Ms Douglas.

MS DOUGLAS: Thank you.

LADY HALLETT: Ms Beattie, who is sat over there.

Questions from MS BEATTIE

MS BEATTIE: Thank you, I ask questions on behalf of Disabled People's Organisations.

In late January 2021, you authored a discussion paper for the NHS England and NHS Improvement board meetings about the progress of the vaccine deployment programme.

Could we bring that up on screen, please. It's INQ000414427.

LADY HALLETT: Could you get on with the question while it comes up.

MS BEATTIE: Yes, certainly.

At page 3 of that document, at paragraph 13, you wrote that:

"The NHS is providing local authorities with visibility on uptake in their communities so they can target engagement appropriately."

Mr Steven Russell in his corporate statement for

NHS England confirms that overall data about disabled people is not available from the National Immunisation Management System. So given that disability data was not recorded, how did local authorities have visibility of vaccine uptake by disabled people in their area, so that they could target engagement appropriately?

A. So this line 13 is the one from my board paper, is that right?

Q. Yes, and I apologise that it hasn't come up.

A. Yes, that's fine. I've got it now. So I think you're partly asking a question about data and data recording about disability, is that right, and about engagement with local authorities on that?

Q. Well, yes, the question is that we've been told that the National Immunisation Management System did not record disability data, which we understand to mean there was no disability data recorded other than perhaps the CEV code about when someone came for vaccination; is that right?

A. It would have contained any information that was in the SNOMED codes for cohort 6, as well, so some learning disability, for example, but not physical disability which wasn't part of the extra morbidity and mortality as defined by the JCVI, yes.

Q. And it wouldn't have contained any disaggregated data on

disability by impairment type, for example?

A. Outside of learning disability, no, I don't think so.

Q. And so given that disability data was not recorded, how did local authorities have visibility of vaccine uptake by disabled people in their area so that they could target engagement appropriately?

A. So I am not aware that local authorities would have had such a data collection. What did happen, as we discussed with the Gypsy, Roma and Traveller groups, earlier, where that's not in the data collection from your GP record and therefore we can't use it to correlate with your vaccination data, is that local engagement, particularly with voluntary and community groups, would enable local authorities to say, "Well, we've got a particular gap here." They wouldn't have had precise, it's 15% of disabled people, for example, but they would have known, you know, there is a problem with access in that the local bus route doesn't take appropriate support in order for people to get on, et cetera. That is something that local authorities would have been able to do through relationships, through their local directors of public health, and through the overall uptake information.

Q. But it's right, isn't it, that the National Immunisation Management System was commissioned in 2020, as a new

system -- (overspeaking) --

A. In the summer of 2020, yes, it was.

Q. And is there any reason that disability data could not have been collected at the point of vaccination in that system?

A. I don't know, and I'm happy to write back to the Inquiry on this, whether there are definitional codes already in NHS systems which NIMS, the immunisation management system would have had to draw on, like, for example, Gypsy, Roma and Traveller is not in the dictionary, or wasn't in the 2001 census definition. So I don't know if there is something to build off or if it would have to be a new data collection but I'm really happy to write back and say exactly what the status was and what the work is ongoing to address that.

Q. So if there is, indeed, a gap, which is what we understand the evidence is, would you agree, then, that that's a necessary improvement that should be made to fill that gap?

A. Yes, depending on -- recognising it might take a fair amount of work to get to agreement on the definitions in the first place, being able to look at that data, I'm sure is something local authorities would -- would find very helpful in terms of commissioning of services, for example.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Beattie. Very grateful.

That completes the questions we have for you, Dame Emily. I'm sure we're all extremely grateful to you for the work that you did during the pandemic and for assisting the Inquiry, both in your statement and your evidence today. You were obviously very measured in your responses. I was very tempted to ask you about the difference between the private sector and the Civil Service but I won't, given the time.

Thank you very much indeed for all your help.

THE WITNESS: Thank you very much.

(The witness withdrew)

LADY HALLETT: 10.00 tomorrow.

(4.45 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X