

Monday, 27 January 2025

1
2 (10.30 am)
3 **LADY HALLETT:** Morning, Mr Mansell.
4 **MR MANSELL:** Good morning, my Lady. The first witness is
5 Darius Hughes, please, if the witness can be sworn.
6 **MR DARIUS HUGHES (affirmed)**
7 **Questions from COUNSEL TO THE INQUIRY**
8 **MR MANSELL:** Could we start, Mr Hughes, by you giving the
9 Inquiry your full name, please.
10 **A.** Darius Bruce Hughes.
11 **Q.** Thank you very much, Mr Hughes, for coming here today to
12 assist the Inquiry. And thank you for the witness
13 statement you have provided for the Inquiry, it's
14 INQ000474453, and that witness statement is provided by
15 you on behalf of Moderna; is that right?
16 **A.** Correct.
17 **Q.** That statement is signed by you and are the contents
18 of it true to the best of your knowledge and belief?
19 **A.** They are.
20 **Q.** I'd like to ask you a few questions about Moderna and
21 your professional background with that company.
22 Moderna, you describe as a group of companies and
23 the first Moderna company was founded in 2010 by
24 scientists as a biotechnology start-up company and
25 a pioneer in the development of messenger RNA vaccines

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1 over 13 billion Covid-19 vaccine doses have been
2 administered worldwide, and more than 70% of the world's
3 population have received at least one dose?
4 **A.** Yes.
5 **Q.** And you explain Moderna has supplied approximately
6 1.5 billion Covid-19 vaccines to date globally?
7 **A.** Correct.
8 **Q.** I want to ask you next about the development of the
9 Moderna vaccine. Is this right: that when the pandemic
10 arose, Moderna had already been conducting foundational
11 research into the field of mRNA-based drugs for a number
12 of years? Is that right?
13 **A.** That is correct.
14 **Q.** And that was in particular in the field of other
15 coronaviruses, including MERS and SARS?
16 **A.** That's correct, yes, since 2010, when the company was
17 first inaugurated, they'd been working on messenger RNA,
18 and most recently they'd been working with the National
19 Institute of Health in America on MERS and other SARS
20 viruses.
21 **Q.** And then, when the pandemic hit, there was a pivot in
22 terms of that technology to focus on Covid-19?
23 **A.** That is correct, yes. We would already have been asked
24 by the National Institute of Health to do an exercise,
25 as it was then, to look at a possible pandemic flu, and

3

1 and therapeutics?
2 **A.** That's correct.
3 **Q.** In fact, the Moderna name reflects that founding
4 principle combining the words "modified" and "RNA"?
5 **A.** Yes.
6 **Q.** The ultimate group parent company is Moderna
7 Incorporated, which is headquartered in the US?
8 **A.** Yes, in Cambridge, Massachusetts.
9 **Q.** You explain you joined Moderna Biotech (UK) Limited in
10 July 2021 as general manager for the UK.
11 **A.** Correct.
12 **Q.** And that's your current role; is that right?
13 **A.** Correct.
14 **Q.** And when you joined in July 2021, you were only the
15 second employee, and you recruited the initial UK team?
16 **A.** That's correct.
17 **Q.** Moderna, as we've heard, produced a Covid-19 vaccine,
18 which was initially known as mRNA-1273, and later by the
19 name Spikevax?
20 **A.** Correct.
21 **Q.** And that vaccine was procured by, and rolled out in, the
22 UK?
23 **A.** That is correct.
24 **Q.** You note this in relation to Covid-19 vaccines: that
25 it's estimated by the World Health Organisation that

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1 instead of performing that exercise, the company pivoted
2 to the SARS-CoV-2.
3 **Q.** The development of the initial Moderna Covid-19 vaccine,
4 including all clinical trials, took place in the
5 United States; is that right?
6 **A.** That is correct.
7 **Q.** And that was expedited under Operation Warp Speed, which
8 was the US government's co-ordination project to
9 accelerate the development of vaccines?
10 **A.** That's correct, yes. The National Institute of Health
11 and the Operation Warp Speed, which was very similar to
12 our Vaccine Taskforce, were working in collaboration
13 with Moderna to accelerate that through, yes.
14 **Q.** In terms of clinical trials for the Moderna vaccine, did
15 they have to meet the same requirements and approvals as
16 if conducted in non-pandemic circumstances?
17 **A.** Absolutely. All of the -- exactly the same criteria.
18 **Q.** I want to focus on the pivotal phase III trial which
19 took place around 27 July 2020. And that enrolled more
20 than 30,000 participants; is that right?
21 **A.** Correct.
22 **Q.** Was that trial eventually relied upon by Moderna as part
23 of its package for authorisation in the UK?
24 **A.** Yes, that was one of the key parts of the package, yes.
25 **Q.** A concern raised by some Core Participant groups is the

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

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

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

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

19 So no suspected unexpected serious adverse reactions
20 during the trials?

21 **A.** Correct.

22 **Q.** And no SUSARs in relation to cardiac events?

23 **A.** None.

24 **Q.** We can turn next, please, to page 6 of this article.

25 And we can see on that page a section -- actually just

5

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

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

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

7

1 above that section, please, we've got "Hispanic or
2 Latino ethnicity", and we've got the percentages there
3 and the number of participants: "Hispanic or Latino",
4 20.5%, 6,235 of the trial participants.

5 And then the next box, please:

6 "Race or ethnic group ..."

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

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

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

17 **Q.** But when we're looking at your figures, the
18 11,000 participants from ethnic minority communities
19 representing 37% of the study population, we must
20 include the Hispanic or Latino group of people within
21 that figure; is that right?

22 **A.** That is correct.

23 **Q.** That can come down, thank you.

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

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1 **A.** Yes, it is.

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

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

11 What we have found in Moderna, we are one of the
12 largest sponsors of clinical trials in the UK, with
13 about one in five of all clinical trials in the UK in
14 2024 being Moderna trials. And what we've found is
15 we've done a couple of different things. One is to try
16 and get the -- bring the clinical trial to the people,
17 to the individuals. So, rather than having them in big
18 hubs or in big hospitals, we try to go out to the
19 population, into local GP surgeries, we're doing a trial
20 with Boots the Chemist, we're also going into some faith
21 areas and places like that to try to get the
22 participants to broaden participation.

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

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

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

9 **A.** That is correct.

10 **Q.** Immunocompromised individuals also excluded?

11 **A.** That's correct.

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

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

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

4 **A.** That is correct.

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

7 **A.** That's correct, yes.

8 **Q.** In relation to that trial you say that the UK Government
 9 encouraged pharmaceutical companies to share clinical
 10 trial sites because there were a limited number of such
 11 sites approved to conduct clinical trials in the UK.
 12 Was this a problem? Would it have helped if there
 13 had been more such sites?

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

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

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

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

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

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

23 **A.** That is correct, yes.

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

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

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

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

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

19 **A.** Mm-hm -- yes.

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

23 **A.** Correct.

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

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

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

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

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

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

22 **A.** That is correct.

23 **Q.** You note that:

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

13

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

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

10 **A.** That's correct.

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

16 **A.** That's correct.

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

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

24 **A.** Yes, it was.

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

15

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

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

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

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

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

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

14

1 **A.** Yes, it was.

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

4 This is dated 1 March 2021.

5 And we can turn to page 47, please.

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

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

11 Talks about:

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

14 Having:

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

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

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

23 Page 49, please.

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

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1 Global Safety Database, weekly literature review,
 2 a continuous monitoring of EudraVigilance, which we know
 3 is the system for managing and analysing information on
 4 suspected adverse reactions to medicines which have been
 5 authorised or been studied in clinical trials in the
 6 European Economic Area. And VAERS, is that Vaccine
 7 Adverse Event Reporting System? Is that a US system?
 8 **A.** Correct.
 9 **Q.** And health authorities websites, reviewing those.
 10 That can come down, please.
 11 In terms of those requirements, any less stringent
 12 than non-pandemic times?
 13 **A.** No, not at all. It was a fairly standard process.
 14 Moderna has got a very large global safety and
 15 pharmacovigilance team and they would be monitoring
 16 those. In fact, I think during the pandemic it was even
 17 heightened in terms of level of vigilance that we were
 18 doing.
 19 **Q.** Let's just go through some of those requirements, then,
 20 at a high level but -- reviewing and assessing safety
 21 data from all external sources?
 22 **A.** Correct.
 23 **Q.** Maintaining a Global Safety Database; we've seen that?
 24 **A.** Yes.
 25 **Q.** Reporting information that Moderna receives about

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1 obligation to undertake post-authorisation safety
 2 studies or PASS, something that we've heard about?
 3 **A.** That is correct, yes. We are undertaking eight
 4 interventional studies and eight non-interventional
 5 studies.
 6 **Q.** In terms of the difference between them, could you just
 7 explain that, please, the difference between
 8 interventional and non-interventional?
 9 **A.** An interventional study is a bit like a clinical trial
 10 where there will be some sort of patient involvement,
 11 whereas a non-interventional study would be really
 12 looking at the literature and pulling together external
 13 data.
 14 **Q.** So 16 PASS; how many published?
 15 **A.** So the interventional studies, four have published, it
 16 says two in my statement but two more have been
 17 published since my statement was done; and for the
 18 non-interventional studies, one.
 19 **Q.** Why not more published?
 20 **A.** It's just the length of time that it takes for them to
 21 run. So a lot of these studies, particularly the
 22 observational studies, the non-interventional studies,
 23 are going to be going on for one, two, three years and
 24 follow-ups of all the patients and data collection. So
 25 it just takes a long time to run them.

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1 adverse events to the MHRA?
 2 **A.** Yes.
 3 **Q.** The Moderna pharmacovigilance team downloading reports
 4 generated by the MHRA on the Yellow Card system --
 5 **A.** That's correct.
 6 **Q.** -- and using that as part of your analysis?
 7 **A.** That would then go into our global safety database, yes.
 8 **Q.** We've seen reviewing and evaluating relevant medical
 9 publications and peer-reviewed journals?
 10 **A.** Mm-hm.
 11 **Q.** Is it right that Moderna held regular meetings with the
 12 MHRA and provided summaries of evaluated safety data to
 13 the MHRA?
 14 **A.** That is correct. Those meetings were weekly in the
 15 height of the pandemic, and was very, very stringent,
 16 and we carried on doing those for quite some time.
 17 **Q.** And in fact is this right: that those reports, the
 18 summaries of evaluated safety data, they were provided
 19 every six months for the first two years to the MHRA --
 20 **A.** Actually, every month for the first six months, yes.
 21 Which is unusual. Normally, it is only every six
 22 months.
 23 **Q.** So there was a heightened requirement in that regard?
 24 **A.** Yes.
 25 **Q.** And is it right that Moderna also undertook an

18

1 **Q.** You may have seen the evidence of
 2 Professor Prieto-Alhambra, one of the Inquiry's safety
 3 experts?
 4 **A.** Yes.
 5 **Q.** In his report, he recommends greater obligations on
 6 pharmaceutical companies to conduct early
 7 post-authorisation safety studies with a particular
 8 focus on ethnic minorities, elderly people with frailty
 9 or multiple comorbidities, pregnant women, and people
 10 with disabilities. What is Moderna's view of that
 11 recommendation, greater obligations on the
 12 pharmaceutical industry?
 13 **A.** So Moderna's priority is always the safety of our
 14 medicines and vaccines, and as such, we would be happy
 15 to collaborate and work with the regulatory authorities
 16 on any of the requirements for post-authorisation
 17 studies that they deemed appropriate.
 18 **Q.** Is it required?
 19 **A.** At the moment, no.
 20 **Q.** Let's look at a particular risk associated with the
 21 vaccine now, myocarditis and pericarditis. And I want
 22 to focus on that, please. It was monitored as an
 23 adverse event within the clinical trials. Is that
 24 because it's a known risk of vaccines?
 25 **A.** That's correct, yes.

20

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

21

1 You explain that more extensive information was
 2 included in the summary of product characteristics on
 3 15 June 2023, with myocarditis and pericarditis noted as
 4 "very rare", in terms of a possible side effect, in the
 5 patient information leaflet dated 25 September 2023; is
 6 that right?

7 A. Correct.
 8 Q. And we can see that, please, this is the information
 9 provided to patients as of that date, INQ000398117,
 10 page 4, please.
 11 "Very rare (may affect up to 1 in 10,000 people)
 12 "- inflammation of the heart muscle (myocarditis) or
 13 inflammation of the lining outside the heart
 14 (pericarditis) which can result in breathlessness,
 15 palpitations or chest pains."
 16 Is this right, that Moderna also prepared with
 17 Pfizer a Direct Healthcare Professional Communication in
 18 July 2021 about the risks?

19 A. That is correct.
 20 Q. Can we see that at INQ00398124, issued by both
 21 companies. Page 2, please.

22 "Call for reporting
 23 "Healthcare professionals are asked to report any
 24 suspected adverse reactions via their national reporting
 25 system ..."

23

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

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

8 Q. Did that lead to the summary of product characteristics
 9 and product information being updated in relation to
 10 Moderna on 25 June 2021?

11 A. It did.

12 Q. And we can see, please, INQ000398119, and page 4,
 13 please. So this is the summary of product
 14 characteristics, and it says there at the bottom of the
 15 page:

16 "Myocarditis and pericarditis

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

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

25 Thank you, that can come down.

22

1 Was this communication the result of a regulatory
 2 requirement?

3 A. It was, yes, from the EMA.

4 Q. But this document, although the focus is Europe, was
 5 also issued in the UK?

6 A. It was.

7 Q. There's no reference in this document to the Yellow Card
 8 Scheme, but there is a reference there to healthcare
 9 professionals reporting suspected adverse reactions
 10 through their domestic schemes.

11 That can come down, please.

12 In terms of the Yellow Card Scheme, does Moderna
 13 have a view on any recommendations for reforms or
 14 improvements to that scheme?

15 A. The Yellow Card Scheme is a very effective way of
 16 collecting adverse events from the healthcare
 17 professionals and from patients. I think the key to it
 18 is the speed with which we can get those adverse events
 19 back to Moderna and into our global safety database, and
 20 therefore we think that the digitisation of the Yellow
 21 Card Scheme as much as possible would be very, very
 22 helpful in getting that speed back. It would allow the
 23 MHRA to pass those safety events on much, much quicker.

24 Q. You note that it would have been useful to have more
 25 accurate data on the doses administered in order to

24

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

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

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

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

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

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

25

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

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

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

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

15 **A.** That is correct.

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

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

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

27

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

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

9 **A.** That's correct.

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

14 **A.** Correct.

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

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

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

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

26

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

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

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

24 **A.** That is correct, yes.

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

28

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

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

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

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

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

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

29

1 So my question is: has there been any change in the
2 import/export requirements for vaccines since April of
3 2021 that would resolve those issues for the future?
4 And if so, what are they?

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

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

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

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

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

31

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

7 **MR MANSELL:** Thank you, Mr Hughes.

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

9 **LADY HALLETT:** He does.

10 Mr Weatherby.

11 Questions from MR WEATHERBY KC

12 **MR WEATHERBY:** Thank you very much.

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

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

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

25 Okay?

30

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

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

13 **MR WEATHERBY:** Yeah. Thank you very much.

14 **LADY HALLETT:** Thank you, Mr Weatherby.

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

18 **THE WITNESS:** Thank you.

19 (The witness withdrew)

20 **LADY HALLETT:** Really grateful.

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

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

25 **THE WITNESS:** Thank you.

32

1 **MS KEMI BADENOCH (sworn)**
2 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4**
3 **LADY HALLETT:** Thank you very much for coming back. Very
4 grateful.
5 **THE WITNESS:** Thank you.
6 **MR KEITH:** Good morning. Could you start your evidence,
7 please, by giving us your full name.
8 **A.** My full name is Kemi Badenoch.
9 **Q.** Ms Badenoch, thank you very much for attending today and
10 also for the provision of your witness statement dated
11 4 July 2024. The Inquiry is, of course, very conscious
12 that you gave evidence -- you've already given evidence
13 in Module 2.
14 **A.** Mm-hm.
15 **Q.** So thank you for coming back.
16 During the period with which this module, Module 4,
17 is concerned, Ms Badenoch, the Minister for Women and
18 Equalities was in fact Liz Truss MP.
19 **A.** Yes.
20 **Q.** But you were Minister for Equalities from
21 13 February 2020 to July 2022.
22 **A.** Mm-hm.
23 **Q.** Whilst for one part of that period you were a minister,
24 I think, in the Treasury, and for another part,
25 a minister in the Department for Levelling Up, Housing
33

1 LGBT issues. So the role changed around the time
2 that I started, which was in -- during Covid, and we
3 bought together other departments which we thought could
4 help deliver a more balanced agenda.
5 I became Minister for Equalities in February 2020.
6 I was actually on maternity leave, so I didn't actually
7 start until April 2020, by which time the pandemic had
8 begun.
9 But if you look at each of those roles, they are
10 doing something specific. Every government minister,
11 every government department, has to deal with equality.
12 It's not something that one -- that only one minister
13 should be looking at, or only a certain set of
14 ministers. It's like having a risk officer or a risk
15 minister. Everyone should be assessing and managing
16 their own risks; everyone should be following the Public
17 Sector Equality Duty.
18 So from that perspective it's not fragmented. And
19 the reason why we have an equalities minister in the
20 Lords is because we need someone who can respond to
21 those questions in the Lords, and just help out.
22 So that was a supporting role rather than evidence
23 of fragmentation.
24 **Q.** So you've referred to the Government Equalities Office.
25 Historically, there have been number of offices or units
35

1 and Communities (DLUHC), at the same time there was
2 a Minister for Equalities, Mike Freer MP, I think in the
3 Department for International Trade, Baroness Berridge,
4 a Minister for Women in the Department for Education,
5 Justin Tomlinson MP and then Chloe Smith MP, ministers
6 for Disabled, in the Department of Work and Pensions.
7 So in the context of a pandemic, and therefore being
8 concerned with the disproportionate impact of a disease
9 on subpopulation groups, and concerned with the take-up
10 and delivery of vaccines, was this ministerial structure
11 rather fragmented?
12 **A.** No, I don't think so. But, to explain that, it's
13 probably important to understand the genesis of these
14 roles.
15 **Q.** Please.
16 **A.** The Government Equalities Office as it started was
17 really created to deliver one policy, which was gay
18 marriage. So this role was created almost as a policy
19 response, and effectively the Minister for Equality
20 position, when -- and especially when joined with the
21 Minister for Women position, was about delivering
22 specific policies for the government of the day rather
23 than looking at policy across all of government.
24 And in particular, certainly until I became Minister
25 for Equalities, its sole focus was really looking at
34

1 within government dealing with separate sectorial
2 issues. So there was a Race Disparity Unit?
3 **A.** Mm-hm.
4 **Q.** A Disability Unit, I think, and a Government Equalities
5 Unit, and all that was brought together in the single
6 Equality Hub --
7 **A.** Yes.
8 **Q.** -- of which we'll hear more?
9 **A.** Yes.
10 **Q.** I think -- and is that the bringing together of those
11 disparate elements of which you speak at the beginning
12 of Covid, I think in September 2020?
13 **A.** Yes. That was a decision that was made by Liz Truss,
14 and we talked about it and agreed that a hub and spoke
15 model was the best way to deliver across the board.
16 A lot of departments didn't really want to think about
17 equality and would rather someone else just had it so
18 they could just focus on delivering. And you will
19 notice that all of us had roles in other departments, so
20 we were not solely focused on equality.
21 This is something that has been challenged several
22 times, I remember being asked about this in the Women
23 and Equalities Select Committee. I do think that that
24 model works, and what it means is that it forces a way
25 of thinking in two departments. Being in the Treasury
36

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

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

14 **A.** Mm.

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

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

37

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

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

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

39

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

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

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

38

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

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

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

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

40

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

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

11 **A.** Yes.

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

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

22 **Q.** All right.

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

41

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

2 **A.** Okay.

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

6 **A.** Yes.

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

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

12 **Q.** And what he says is:

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

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

20 **A.** Mm.

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

25 Again, we don't use that phrase nowadays.

43

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

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

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

12 **A.** Yes.

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

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

42

1 "There were concerns with the level of
 2 anti-vaccination messaging ... Local community champions
 3 ..."

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

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

14 **A.** Mm-hm.

15 **Q.** -- and the need to monitor effectiveness.

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

20 **A.** Mm-hm.

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

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

44

1 to this issue.

2 **A.** Mm.

3 **Q.** It's obviously referred here at the highest level, and

4 we'll see in a moment it's referred to in Cabinet?

5 **A.** Mm.

6 **Q.** But did the government, do you assess, get on top of

7 these issues as quickly and as effectively as it could

8 have done?

9 **A.** So specifically on data --

10 **Q.** Well, actually all of this, but data is an important

11 part of the topic.

12 **A.** So data was the biggest challenge. This might be

13 because the unit that I was overseeing, the Race

14 Disparity Unit, was a data unit, and so we would have

15 been more interested, perhaps, in data than others. But

16 we constantly encountered issues in just finding out

17 what was going on.

18 Sometimes that was because the data hadn't been

19 collected in the first place so there was nothing to

20 look at, and finding out whether it had or had not been

21 collected could also be a challenge. So you didn't know

22 whether there was something to see and we couldn't find

23 it, or there was nothing to see.

24 Then there was the issue of people having data, but

25 not wanting to share it because of the conditions that

45

1 **A.** Yeah.

2 **Q.** So the problem wasn't a shortage of data. Was it -- did

3 the problem lay in its -- did it lie in its production

4 in a useful form to decision makers?

5 **A.** There was a shortage of data. Just because there's lots

6 of data, doesn't mean that it's what you're looking for.

7 So in terms of -- if you're talking about volume, yes,

8 there was lots of data. But I remember us trying to

9 find out the ethnicity of people who had been dying,

10 especially the frontline ethnic minority workers in the

11 NHS. We didn't have that. So my first quarterly report

12 I think talked about the mandatory collection of that

13 sort of data. So there were still things missing --

14 **Q.** So, at the beginning, there was a specific problem with

15 the recording of ethnicity data amongst patients in

16 hospitals and also amongst --

17 **A.** Staff.

18 **Q.** -- those who died from Covid?

19 **A.** Yes, and it took this a long time to get this resolved.

20 The hoops that needed to be jumped through, I was

21 told -- because I wasn't the one carrying out the data

22 collection, but I was told by my team that it was quite

23 difficult. And I know they eventually got there.

24 But you are right, across multiple systems, whether

25 it's OpenSAFELY, ONS, and so on, there is data.

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1 they had been given when they were collecting it in the

2 first place, GDPR, consent, and so on, and probably

3 a third bucket of there being an issue of trust or not

4 wanting to collaborate with others, people wondering why

5 do you need this data? Don't worry about it. We can do

6 this ourselves. We don't need you to look at it.

7 So a level of competition, perhaps, or just

8 suspicion about why other groups are carrying out work

9 which perhaps some units may have felt was solely within

10 their purview.

11 I can't remember specifically where these other

12 bodies were. I know some of it was in academia, a lot

13 of it was in the NHS, just getting information out of

14 the NHS I found was the hardest thing.

15 **Q.** Presumably, there are any number of systems within

16 government for the recording and dissemination of data.

17 **A.** Mm.

18 **Q.** In ONS, there's obviously data there?

19 **A.** Mm-hm.

20 **Q.** Public Health England, UKHSA, as it then became.

21 NHS England obviously has data. GPs. There were

22 a number of observational studies.

23 **A.** Mm.

24 **Q.** UK-REACH, OpenSAFELY, which had access to millions of

25 records.

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1 Sometimes the data that you have is not necessary --

2 it's not live; it's old. And the systems are set up to

3 do different things. They don't necessarily use the

4 same categorisation to reference the same information.

5 And that is understandable because these things have

6 cropped up in different ways; they've been set up for

7 different purposes.

8 **Q.** We'll move forward and look at, in fact now, your final

9 report, the final -- the fourth quarterly report, dated

10 1 December. Because there was much in that, wasn't

11 there, about data, and you made number of

12 recommendations about how to better accumulate --

13 **A.** Yes.

14 **Q.** -- and publish and then rely upon data.

15 Can we have INQ000089747, please.

16 This the fine report, dated December 2021.

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

18 There is an overview and executive summary. This

19 was obviously the fourth report, and so it builds upon

20 the learning and the knowledge which was set out in the

21 earlier reports.

22 **A.** Yes.

23 **Q.** And this page is concerned with the increase in your

24 understanding, your better understanding of the risk

25 factors involved in the pandemic. At the bottom of the

48

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

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1 piece of work. We've carried out recommendations. But
 2 I'm -- at this point I'm thinking: well, we're going to
 3 have to go back to our day-to-day, how do we make sure
 4 that this work carries on and people understand the
 5 lessons learnt?
 6 So the hope was that new office for health
 7 disparities -- I'm sorry, I genuinely can't remember the
 8 name of it now, but I know that it is in existence --
 9 would be picking up this sort of work and running with
 10 it.
 11 **Q.** As it happened, the government commissioned a report
 12 into health data, it's called the health data review,
 13 and it was led by Professor Cathie Sudlow.
 14 **A.** Mm.
 15 **Q.** It reported in November of last year, 2024. I wanted to
 16 ask you, and I appreciate it's not something that you've
 17 been required to look at, but I wanted your impression.
 18 **A.** Mm.
 19 **Q.** Amongst the five recommendations that Professor Sudlow
 20 made were these two recommendations: that there should
 21 be a national health data service in England for health
 22 data; and secondly, that there should be a UK-wide
 23 approach to streamline data and, therefore, to better --
 24 well, to improve understanding by all the governments
 25 within the four nations of the impact of the data and

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1 Ms Badenoch, this fourth report was published in
 2 December 2021.
 3 **A.** Mm-hm.
 4 **Q.** So the end of 2021, at the end of the second year of the
 5 pandemic. You were calling for, and making
 6 a recommendation to this effect: for relevant health
 7 departments and agencies to review and action existing
 8 requests for health data and to carry out a strategic
 9 review.
 10 May we take it from the fact you were still calling
 11 for this, and you were making a recommendation to this
 12 effect at the end of December 2021, that, by that stage,
 13 the system was still not working as well as it might?
 14 **A.** I think this was really a forward look, because there
 15 was -- and I can't remember the exact name now, but
 16 there was a new office for health disparities that
 17 was -- that was to be set up.
 18 **Q.** Indeed.
 19 **A.** And I wanted to make sure that it was starting with the
 20 knowledge which we had accrued and starting with some of
 21 those actions, and actually able to monitor them. So
 22 the Equality Hub, doing this work, was always
 23 a time-limited thing. We certainly did not have the
 24 resources to monitor what every department was doing
 25 throughout. So this was a discrete project, a discrete

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1 what can be learned from it.
 2 Are those two recommendations something that you
 3 would endorse? Was it your view that something did need
 4 to be done about setting up a national data service and
 5 having a consistent aggregated approach across the
 6 United Kingdom?
 7 **A.** Yes, with caveats. So yes, I do think some streamlining
 8 and rationalisation of data sources is necessary, and
 9 also making sure that we're using the very best labels,
 10 the very best categorisation, because it is confusing.
 11 You know, you talked about the use of the term "BAME" --
 12 there was so -- there's a plethora of labels that was
 13 being used. We never knew whether we were all talking
 14 about the same thing or not.
 15 So yes, in principle, I do think that that is
 16 something that should be done. I don't know the genesis
 17 of Professor Sudlow's work, but I have come to this
 18 conclusion via separate avenues.
 19 However, there is a challenge now with how well
 20 government itself is placed to deliver this sort of
 21 system. And I remember, it's over 20 years ago now,
 22 when I was working on a project for the NHS Spine, when
 23 we were supposed to have a National Health Service, you
 24 know, IT system, and it failed. Government is not
 25 necessarily great at delivering these systems. They

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

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

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

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

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

25 **A.** Mm.

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1 that can make things slower.

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

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

22 **A.** Mm.

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

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

5 **A.** Mm.

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

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

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

13 It's obvious that your quarterly reports made
 14 a number of serious and considered recommendations.
 15 Your first report made 13 recommendations. There were
 16 a number of recommendations in the second report. And
 17 then in the final report I think there were as many as
 18 17 recommendations.

19 The fact that the reports worked on and then
 20 published, over a considerable amount of time, from
 21 1 February 2021 to the end of 2021, rather suggests that
 22 the government was having difficulty getting traction in
 23 getting change brought about. Would you agree?

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

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

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

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

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

24 **Q.** Just expand on --

25 **A.** -- (overspeaking) -- hoping --

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

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

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

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- 1 it was working but exactly how or why, it was just
2 really difficult to get a good feedback.
3 **MR KEITH:** My Lady, is that a convenient moment?
4 **LADY HALLETT:** Certainly.
5 I'm sorry we have to break, Ms Badenoch, but
6 I promise you, you will finish your evidence before
7 lunch so you can return to other duties.
8 **THE WITNESS:** Thank you.
9 **LADY HALLETT:** I shall return at 12.05.
10 **(11.50 am)**
11 **(A short break)**
12 **(12.05 pm)**
13 **LADY HALLETT:** Mr Keith.
14 **MR KEITH:** Ms Badenoch, I was asking you about your meetings
15 with high commissioners.
16 **A.** Yes.
17 **Q.** Just been asked to raise a particular point in
18 connection with that issue. You said that the meetings
19 weren't terribly effective, not because there was a lack
20 of will, perhaps, or willingness to assist, but perhaps
21 because it didn't lead to a visible improvement in the
22 position in terms of the diaspora from each of those
23 countries taking up the offer of vaccination, which
24 I think was the point of the meetings?
25 **A.** Yes, and also because I think we were asking them to do

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

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

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

16 **Q.** Yes.

17 **A.** But those cohorts, certainly asylum seekers, refugees,
 18 would have other interactions in the public health space
 19 and they would have other points of contact.
 20 With illegal immigrants, this is a more fundamental
 21 question. These are people who are not in the country
 22 legally. Then -- so effectively committing a crime even
 23 by being here. Their interactions with the state will
 24 be minimal to none, because they will be worried about
 25 being --

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

8 **Q.** Can we have INQ000477623, please.

9 This is an agenda for a National Pharmacy
 10 Association meeting with you, and Nadhim Zahawi, the
 11 Minister for Covid Vaccine Deployment, on
 12 7 January 2021.

13 **A.** Mm.

14 **Q.** The attendees, and in particular the representatives of
 15 the National Pharmacy Association, make the point very
 16 strongly indeed that there is a very wide network of
 17 pharmacies across the United Kingdom, 14,000 in all,
 18 that they are a diverse profession, and then -- over the
 19 page -- you can see references to how:
 20 "Community pharmacists have a trusted relationship
 21 with patients ... [they're] well placed to dispel
 22 myths ..."
 23 They have a great deal of regular face-to-face
 24 contact with the public and I think it was well known
 25 that pharmacies tend to operate in areas of greater

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1 **Q.** Reported?

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

7 **Q.** All right.

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

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

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

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

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

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

15 **A.** Well, I wouldn't know, because -- I mean, this is an
 16 agenda for a meeting. These aren't the minutes. Just
 17 looking at the structure. This is an agenda for the
 18 meeting, so this discussion was had, and at the end
 19 of it there would have been a recommendation.
 20 I recollect community pharmacies being used, but the
 21 conditions would never have been determined by my unit,
 22 and I would not have been aware of the success in terms
 23 of deployment of vaccines.
 24 My understanding was that they did do that, but it
 25 may have been only those that opened for the full

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1 12 hours. And I don't know what the reasons for that --

2 **Q.** All right.

3 **A.** -- I don't know what the reasons for that were.

4 **Q.** From the paperwork produced by your department, it's

5 also obvious that there were a great deal of, many

6 meetings with local authority leaders --

7 **A.** Mm-hm.

8 **Q.** -- and time spent debating how local authorities could

9 step into the breach and ensure that public health

10 messages were disseminated and that members of the local

11 populations would take up the offer of a vaccine. By

12 and large, do you think that local authorities were used

13 enough? It is obvious that in any system of national

14 vaccination, that it has to be driven by the centre, and

15 obviously questions of prioritisation and manufacture

16 and delivery have to be driven by central government.

17 **A.** Mm.

18 **Q.** Do you think local government played or was asked to

19 play a sufficiently important role?

20 **A.** I think so. I wasn't in DLUHC during the height of

21 this. By the time I came into that department, a lot of

22 this work had been done and it wasn't, strictly

23 speaking, within my policy area. But I do recall

24 multiple meetings being had with leaders of local

25 authorities. I think that what you've described is

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1 understanding and my own personal experience, I thought

2 that was what they were doing.

3 **Q.** How effective was the Community Champions scheme, which

4 was something very much at the heart of your

5 department's response?

6 **A.** Actually, Community Champions was a DLUHC-sponsored

7 scheme. We advised, and they were already carrying out

8 a Community Champions scheme. We advised on how it

9 could be used to deliver the objectives of the work that

10 we were doing. So we worked in partnership with them,

11 but it was actually Levelling Up, Housing and

12 Communities' responsibility, the Communities department

13 led on Community Champions and we fed in. And we gave

14 them a lot of insight and a lot of intelligence on where

15 to go, I think, and how to make sure that it was

16 successful. But the delivery of it was actually in

17 DLUHC. And I think that they did do a good job. It

18 wasn't everywhere.

19 So Community Champions was specifically in those

20 places where we thought people were hard to reach, and

21 my understanding and the reports which we got back,

22 which I don't have to hand, but I had a better feedback

23 mechanism from what Community Champions were doing than

24 I did on the communication angle, where we just weren't

25 sure what was working and what wasn't.

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1 really more appropriate for directors of public health

2 who work in conjunction with local authorities, the

3 integrated care boards.

4 Local councils have a very specific remit when it

5 comes to health delivery, and I think that this would

6 be, you know, giving them more to do would be quite

7 a challenge. It's not what they're used to doing.

8 I think it's the directors of public health and using

9 the health mechanisms locally, rather than the local

10 authorities specifically.

11 **Q.** But aren't they the bodies who are most likely to know

12 what the state of deprivation is locally, the degree to

13 which vaccines were not being taken up by ethnic

14 communities, and also what, practically, on the ground,

15 could be done in terms of going door to door, to

16 housebound residents and making sure --

17 **A.** Yes.

18 **Q.** -- that they were vaccinated? Isn't that a local

19 authority issue?

20 **A.** It is, but that, I think, they did well. I mean, I saw

21 what my local authority did, and I thought that they did

22 that fairly well. But in terms of the more clinical

23 public health aspects, I would expect the advice to be

24 coming from the Director of Public Health, the delivery

25 levers perhaps using local authorities. But from my

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1 **Q.** And what is the great value of a Community Champion? Is

2 it to do with being able to provide for a high-profile,

3 trusted local figure whose messages about vaccination

4 will be believed and accepted and could raise the

5 profile, of course, of -- in public health terms, of

6 what the government is seeking to do?

7 **A.** Yes, that, but also they know what's going on in a way

8 that those of us with offices in Whitehall will never

9 know what's happening in a particular local community.

10 They have a better understanding, better

11 intelligence, and they are part of those communities, so

12 they want them to be, you know, healthy and successful.

13 They have a vested interest in seeing things work.

14 **Q.** Mis- and disinformation. Your fourth quarterly report

15 made a number of recommendations concerning trying to --

16 or what could be done to dispel myths, reduce fear and

17 build confidence amongst ethnic minority people. Was

18 the further work that you identified -- and it was in

19 your first quarterly report of October 2020 -- was that

20 further work done, do you know?

21 **A.** No, I don't know how far the work was taken. I know

22 that there is, or certainly there was, a unit that

23 looked at this, but they looked at misinformation and

24 disinformation across the board, and a lot of its work

25 is very sensitive.

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1 Q. Can we have a look at INQ000089742. This is
 2 Ms Badenoch's statement -- no, I think it's the first
 3 quarterly report and page 62.
 4 No, I think I must have the page reference wrong
 5 there.
 6 We'll try one more. Can we have INQ0000897 -- no,
 7 I think we'll leave it there.
 8 Two pages of the first quarterly report set out, in
 9 quite significant detail, the degree of prevalence of
 10 misinformation and disinformation.
 11 A. Mm.
 12 Q. In terms of countering dis- and misinformation amongst
 13 ethnic minority groups, is there a limit on what central
 14 government can do?
 15 A. There's always a limit on what central government can
 16 do. I think it's probably worth explaining what it is
 17 that I mean by misinformation and disinformation.
 18 People often assume that it's, you know, stuff on
 19 Twitter or X. I'm actually less worried about that sort
 20 of misinformation because it's very public and people
 21 who know can challenge it easily. So that's an open
 22 sphere.
 23 The things that really concern me are the pieces of
 24 information that are less visible. The last time I was
 25 here I talked about WhatsApp groups, for example, family

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1 But I don't know the answer to dealing with that
 2 sort of back channel information that's peer-to-peer and
 3 private beyond the government supplying as much honesty
 4 and as much truth as possible. And also not attacking
 5 the people who are propagating these. So as annoyed as
 6 I was by, you know, representatives of the British
 7 Medical Association saying these things, what I didn't
 8 do was go after them, because that can actually fuel the
 9 misinformation or the conspiracy.
 10 Q. All right.
 11 In your final quarterly report you made seven
 12 recommendations, all of which, I think, were accepted by
 13 the then Prime Minister in full; is that right?
 14 A. (No audible answer).
 15 Q. And I just want to focus on a handful of them.
 16 Recommendation 6, and you've just referred to the
 17 issue of clinical trials, recommended that confidence be
 18 built in future vaccination schemes by increasing ethnic
 19 minority participation in clinical trials.
 20 A. Mm.
 21 Q. Was it your view, at the time of the promulgation of the
 22 report that there had been insufficient diversity in
 23 clinical trials? We've had a great deal of information
 24 and evidence about the actual figures for diversity in
 25 the clinical trials on the part of all three of the

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1 WhatsApp groups, things that government has no insight
 2 into. Even the tech companies don't really know what's
 3 being shared, it's all encrypted, and a lot of false
 4 information travels very quickly through those channels
 5 and I don't know how we can deal with that. And it's
 6 everything from "vaccines will kill you" to "the
 7 government is suppressing information". In fact, some
 8 of it often has, you know, likely reputable sources who
 9 are backing it up.
 10 I remember we had some people from the BMA who
 11 genuinely believed that we were trying to stop
 12 information from getting out about what was happening
 13 with the ethnic minorities. And when you see that on
 14 a public forum you'll think, "Oh well, well if the
 15 doctors in the BMA think that, then it must be true",
 16 but even they were wrong and then that starts to
 17 propagate. And the thing that government can do best is
 18 provide as much information as possible and show that we
 19 are, you know, that we're all in it together.
 20 That was one of the reasons why I decided to take
 21 part in vaccine trials, that if people thought that the
 22 government was trying to kill them, then if the minister
 23 herself was taking part in trials which are more risky
 24 than a fully-tested vaccine, that might help with public
 25 trust.

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1 Covid-19 UK vaccines. But was it your view that
 2 certainly in the public sphere, there was a lack of
 3 confidence in vaccination, in part contributed to by
 4 a belief -- rightly or wrongly -- that there was a lack
 5 of diversity?
 6 A. No, I think it's -- there's a lot of "yes" and "no" in
 7 that. I think it's more complex. So let me try and
 8 unpack this. Within ethnic minority communities,
 9 irrespective of what's happening here, there is distrust
 10 of public authority. Most ethnic minorities have come
 11 from authoritarian regimes or places where the
 12 government may actually be trying to get you, and that's
 13 why they've come here. So there is a baseline level of
 14 suspicion that is just higher than we in the UK have
 15 generally, and it builds from that.
 16 So when we're looking at the lack of trust, we've
 17 got to have that in mind, that there is a cultural
 18 aspect here that shouldn't be ignored.
 19 Do I think that it is true that ethnic minorities
 20 did not participate in vaccine trials? Yes. First of
 21 all, for that reason. Secondly, just because it just
 22 wouldn't have been -- it's just harder if you are in
 23 a community that's more likely to be closed, if levels
 24 of education are lower, it's not something that you
 25 would ordinarily do. I think that that's right, but

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

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

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

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1 meantime?
 2 **A.** Absolutely.
 3 **Q.** Like you were saying.
 4 And more generally, those relationships need to be
 5 nurtured and pursued, not just in the narrower context
 6 of vaccination and the impact of a pathogenic
 7 outbreak --
 8 **A.** Yes.
 9 **Q.** -- but generally, so that they're ready to go --
 10 **A.** Yes. And not just top-down but also bottom-up as well,
 11 which is -- which I know is harder but it tends to be
 12 more long lasting.
 13 **MR KEITH:** All right. Thank you very much indeed.
 14 **LADY HALLETT:** Thank you, Mr Keith.
 15 There are just a few more questions for you,
 16 Ms Badenoch.
 17 Mr Thomas, who's over there, will start. Thank you.
 18 **Questions from PROFESSOR THOMAS KC**
 19 **PROFESSOR THOMAS:** Good morning, Ms Badenoch, can you hear
 20 me?
 21 **A.** Yes, I can.
 22 **Q.** I'm representing FEMHO, the Federation of Ethnic
 23 Minority Healthcare Organisations, and I've only got
 24 a small number of questions for you.
 25 **A.** Okay.

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

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

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

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

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

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1 that workable.

2 But even I understood the arguments that others were
3 making about why such a policy would be necessary.

4 I didn't agree on balance that we were in the right
5 place. I also, even with the BAME Communities Advisory
6 Group, didn't want us to overplay the significance of
7 the risk there.

8 **PROFESSOR THOMAS:** Madam, thank you very much.

9 **LADY HALLETT:** Thank you very much, Mr Thomas.

10 Mr Jacobs.

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

12 **THE WITNESS:** Yes, I can.

13 **LADY HALLETT:** Behind the pillar, yes.

14 Questions from MR JACOBS

15 **MR JACOBS:** Ms Badenoch, good afternoon.

16 **A.** Hello, good afternoon.

17 **Q.** I represent --

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

19 **MR JACOBS:** Can you hear me?

20 **LADY HALLETT:** Yes, I can now.

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

25 You cite in your evidence a number of initiatives

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

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

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

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

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1 that were taken to increase vaccine confidence in
2 minority communities.

3 **A.** Mm-mm.

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

8 **A.** Yes.

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

12 **A.** Mm.

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

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

21 So my understanding is that there were activities.

22 I also know that of all of the groups that we were
23 trying to reach, that was the most difficult group.

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

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

14 You need people who spend a lot of time, probably of
15 that community, who can do this. And if the culture
16 within the community is one that is to not interact with
17 the state it just creates a tension that's very, very
18 difficult to overcome.

19 **Q.** Thank you. I have one final question for you. You
20 discussed Community Champions earlier on in your
21 evidence.

22 **A.** Mm.

23 **Q.** And you say in your statement that the Community
24 Champions scheme allocated £23.75 million in funding 60
25 councils, and was designed to expand work to support

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1 communities?

2 **A.** I would be surprised if the level of knowledge in local
3 authorities was that low, purely because, from the
4 experience I have seen over the last 10 years, local
5 authorities know exactly where Traveller communities are
6 because everyone around tends to complain and not want
7 them there. They are very, very knowledgeable about
8 where the communities are. How to get into them is
9 trickier, but I am not sure that, you know, just to the
10 question you're asking about data collection --

11 **Q.** Yes.

12 **A.** -- I'm not sure that Community Champions was reliant on
13 data in that way. The purpose of Community Champions
14 was that they had the local knowledge, you know, in
15 their heads, almost, and it shouldn't -- if we had had
16 all the data we wouldn't have needed the Community
17 Champions, so I'm not sure that that's how we would have
18 resolved that particular issue.

19 **MR JACOBS:** Okay, I don't think I have any more questions
20 for. I'll just ask. No, I don't. Thank you very much.

21 **THE WITNESS:** Thank you.

22 **LADY HALLETT:** Thank you very much, Mr Jacobs.

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

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1 those most at risk from Covid-19, and boost vaccine
2 take-up. That's right, isn't it?

3 **A.** Yes.

4 **Q.** And Yvonne MacNamara, who is the CEO of the Traveller
5 Movement, she gave evidence on 16 January, and she said
6 that there's been a historic problem that the GRT
7 Traveller ethnicity is not recorded by institutions.

8 **A.** Is not, sorry?

9 **Q.** Is not recorded by institutions.

10 **A.** Recorded.

11 **Q.** And the example that she'd gave is that the GRT are not
12 recorded in the NHS Data Dictionary. Now, we've been
13 looking at the final quarterly report, and I know that
14 it makes that point, doesn't it?

15 **A.** Mm.

16 **Q.** As a consequence of this lack of recording in relation
17 to data, Ms MacNamara said that local authorities just
18 didn't know how many Travellers lived in their areas
19 because of this data capture issue.

20 **A.** Mm.

21 **Q.** My question is: do you think, Ms Badenoch, that the
22 Community Champions scheme was actually unable to boost
23 vaccine take-up by Travellers because of this inadequate
24 data capture issue, particularly in England, meaning
25 that GRT people were not sufficiently visible to local

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1 **THE WITNESS:** It sounds like you were inviting me again.

2 **LADY HALLETT:** Well, I can't make any promises but I do
3 promise -- I can't make any promises we won't ask you
4 back, but I do promise that we'll do our very best to
5 limit any burden upon you. So thank you very much for
6 your help so far.

7 **THE WITNESS:** Thank you. I'm very grateful for that; thank
8 you so much.

9 **LADY HALLETT:** Thank you.

10 (The witness withdrew)

11 **MR KEITH:** My Lady, that concludes this morning's evidence.

12 **LADY HALLETT:** Thank you. I shall return at 1.40.

13 (12.37 pm)

14 (The Short Adjournment)

15 (1.40 pm)

16 **LADY HALLETT:** Ms Stephenson.

17 **MS STEPHENSON:** My Lady, the next witness is Nadhim Zahawi.
18 Please can the witness be sworn.

19 **MR NADHIM ZAHAWI (sworn)**

20 **Questions from COUNSEL TO THE INQUIRY**

21 **LADY HALLETT:** I hope we haven't kept you waiting and you
22 were warned that you wouldn't be on until this
23 afternoon.

24 **THE WITNESS:** Not at all, we've got 20 minutes early.

25 I thought I was going to come in at 2.

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

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

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

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

10 **Q.** Thank you.

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

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

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

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1 respect of oversight, please?

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

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

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

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

4 **A.** That's right.

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

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

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

18 **A.** That's correct.

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

20 **A.** Yes, that's correct.

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

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

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

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

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

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

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

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

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

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

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

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

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1 SRO in NHS England for vaccine deployment.

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

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

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

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

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

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

22 **A.** Very much so. Absolutely.

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

25 **A.** Yes, absolutely.

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

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

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

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

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

12 INQ000399454, please.

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

15 If we could move to page 7, please.

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

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

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

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

7 **A.** Yes, absolutely.

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

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

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

4 **A.** Mm-hm.

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

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

17 If we could then turn to page 33, please.

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

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

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

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1 choice of places and the aim to have everybody within
2 10 miles of a vaccination service, that at this point
3 efficiency and scale was the priority for the programme?
4 **A.** I think that's right. If you remember what I said at
5 the outset, the constraint is vaccine manufacturing, ie
6 limited supply, which we knew was going to be the real
7 challenge here, not just for the United Kingdom but for
8 Europe and the rest of the world. And therefore, how do
9 you maximise the protection of the nation? Hence why
10 that sort of shaped the way we planned -- the way the
11 team planned the deployment.

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

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

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

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

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

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

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

4 **A.** Absolutely right.

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

6 **A.** Absolutely.

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

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

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

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

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

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

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

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

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

17 **A.** Mm.

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

20 "DH -- some further lessons ... On the ground, we
21 faced a huge amount of disinformation -- particularly on
22 social media. Found it was often circulating in
23 [particular] places ... able to feed [into] distrust ...

24 Wish we had been more proactive with local authorities
25 and involved them at an earlier stage ... Local

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1 politicians are very useful and often know which
2 community [and] faith leaders to talk to ..."
3 Keith Vaz is an example of helpful intervention in
4 Leicester.

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

8 Thank you. We can take that down.

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

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

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

4 And the next paragraph, please.

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

9 Thank you, we can take that down.

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

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

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1 great to see.

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

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

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

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

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

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

25 "Local councils and Directors of Public Health are

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

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

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

4 **Q.** Did the situation subsequently improve --

5 **A.** Yes.

6 **Q.** -- as that system but became --

7 **A.** -- that's my point.

8 **Q.** -- became more sophisticated?

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

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

16 **A.** Much better.

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

20 **A.** Very much -- very much so.

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

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

3 Thank you, we can take that down now.

4 And in fact on the same day, I think, you attended,
 5 7 January 2021, the same day as the email we've just
 6 looked at, a meeting with representatives from the
 7 National Pharmacy Association who stressed the
 8 importance of pharmacies reaching local communities.

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

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

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

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

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

10 **A.** Yes.

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

24 **A.** -- (overspeaking) --

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

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

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

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

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

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1 consideration of vulnerable or marginalised groups and
 2 the steps taken to increase uptake.
 3 Before rollout began, it was plainly anticipated by
 4 the government, wasn't it, that the uptake of
 5 vaccinations was likely to be lower amongst ethnic
 6 minority groups and amongst other vulnerable groups, and
 7 you understood that as well when you entered your role;
 8 is that right?

9 **A.** Very much so.

10 **Q.** A vaccine uptake plan was published on the 13 February
 11 2021, signed off by you and by the Secretary of State.
 12 And it set out a plan to address the disparities in
 13 uptake and also to represent what steps had been taken
 14 to that point.

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

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

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

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

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

20 So "Being invited for an appointment".

21 **A.** Mm.

22 **Q.** This part of the plan recognises:

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

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

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

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

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

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

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1 asylum or simply because an individual chooses not to."

2 And then it's explained that:

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

8 Thank you, we can take that down.

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

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

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

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

22 **Q.** Focusing on those vulnerable groups --

23 **A.** Yes.

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

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

6 **A.** No, you're absolutely right.

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

9 If we could have INQ000401097 up, please.

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

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

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

25 **A.** That's correct.

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1 Thank you. We can take that down.

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

4 **A. (Witness nodded)**

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

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

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

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

5 **A.** Correct.

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

8 Just looking at the next paragraph:

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

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

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

18 The next paragraph makes it plain that:

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

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

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

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1 in the future?

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

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

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

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

25 It's clear from your evidence and from the evidence

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

12 So why do you think that those disparities
13 persisted, despite the efforts that were made?
14 A. Yeah, and I would just add one other thing. So we
15 deliberately, you know, didn't engage with anti-vaxxers,
16 but we also then deliberately wanted to engage with
17 vaccine-hesitant, you know, individuals and groups,
18 because of that misinformation and disinformation, that
19 that can impact their decision. And I think -- and, you
20 know, without having -- going over each and every
21 initiative, but I think we really did some really good
22 things in community, especially engaging with those from
23 the community who happened to be in the health service,
24 clinicians and others, because they would have the most
25 trusted voice in the sort of hierarchy of trust with the

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

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

5 We can see that this is an advice to you and the
6 Secretary of State at the time, Sajid Javid, regarding
7 Valneva and the decision on termination dated
8 9 September 2021.

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

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

16 Then at 9:

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

20 Then the position is reserved on Clinical Trials
21 Agreement.

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

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

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1 state.

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

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

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

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

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

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

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

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

14 So we can take that document down now entirely.

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

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

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

6 So the question is this: to what extent was
7 consideration given to the UK's wider relations with
8 industry when deciding to cancel the contract? That is,
9 the effect on relationships with the pharmaceutical
10 companies that the UK might work with in the future,
11 their willingness to work with the UK if it was
12 considered that contracts taken on at risk might be
13 cancelled in this way. Did you consider that?
14 **A.** The simple answer is yes. You know, I don't know how
15 much of my background you know. I was -- I have very
16 much a commercial background before entering politics,
17 and, on the face of it, an inactivated virus technology
18 could have, should have maybe worked. The VTF didn't
19 deliver their advice out of gut instinct; it was based
20 on evidence. And I attended that meeting with the --
21 with Jonathan Van-Tam, the Deputy Chief Medical Officer,
22 and the expert team, who took us through the data. You
23 know, as a booster, it just didn't work. Even compared
24 to the placebo. Right?

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

20 When we flicked that switch and opened up the data,
21 and as the nation can see, you know, as we began to
22 really scale the deployment and build the numbers, the
23 sentiment very quickly flipped from despair to hope, and
24 then to belief that, you know, we are going to deliver
25 this, we're going to do this and we're going to do it
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1 make, but it's evidence-led and based, and that's the
2 only way you should make decisions in government. Or
3 even in the private sector. You know, in the commercial
4 world, you know, if I was the leadership at Valneva, the
5 evidence is the evidence. I can't change those facts,
6 and I think it was absolutely the right decision.

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

20 **Q.** Finally, then, turning to your recommendations or the
21 lessons learned which you set out in your statement.
22 You described the use of data as an important lesson
23 learned. Is that to do with the positive lesson to be
24 learned from the sharing of data on a daily basis, daily
25 figures, and transparency with the public which you
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1 together. And then it obviously filtered back into
2 confidence, and people actually coming forward and
3 getting themselves vaccinated.

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

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

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

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

22 Questions from MR WAGNER KC

23 **MR WAGNER:** Thank you, good afternoon. I represent
24 Clinically Vulnerable Families which does what it says
25 on the tin: represents the clinically vulnerable, the
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1 clinically extremely vulnerable and the
2 immunosuppressed.

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

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

18 **A.** So I -- obviously, in my role as the vaccine deployment
19 minister, met a number of groups representing the
20 clinically vulnerable, and not least, by the way, and
21 didn't get much of a mention today, but I have to say we
22 initiated an engagement with MPs and peers and we'd get
23 hundreds, in the early days literally almost every MP
24 would be on the call and I would be flanked by Jonathan
25 Leach from the NHS and Professor Anthony Harnden from
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1 Absolutely. But my experience of those centres and the
2 people that worked in them, they took their
3 responsibility incredibly seriously, and did everything
4 in their capacity to be places that will protect those
5 that are clinically vulnerable. So I think in many
6 ways, I guess, you know, going forward, can we do more?
7 Of course. You know, we can go back and learn exactly
8 how, you know, how we can do better for the clinically
9 most vulnerable in a pandemic, but those centres were,
10 in my view, really, you know, built for safety.

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

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

24 **MR WAGNER:** Thank you.

25 **LADY HALLETT:** Thank you, Mr Wagner.
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1 the JCVI and we'd take all questions, including from
2 their constituents who are clinically vulnerable, and
3 actually, that was a great piece of innovation, because
4 it was a fantastic radar screen where we picked up stuff
5 very early, including vulnerability of pregnant women,
6 for example, and prioritising clinically vulnerable with
7 the 70 to 74 age group, ie, very early on in
8 vaccination.

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

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

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

25 **A.** If you're asking me could we always, you know, do more?
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1 Ms Naik, who is usually over that way. There
2 she is.

3 Questions from MS NAIK KC

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

23 So what specific steps were you referring to in your
24 witness statement? What targeted steps, other than
25 those that you've already told us about, for example
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1 your national radio appearance, but what else was there
 2 that you actually did?
 3 **A.** Well, I think you have just referred to it again. So
 4 other than the plan, we made sure that from the top, ie,
 5 from the minister, myself, and through the organisation,
 6 we, you know, engaged in outreach, including myself, you
 7 know, engaging with media outlets that those particular
 8 groups we knew were listening to, were reading, to be
 9 able to say very clearly, "Look, you're hearing from the
 10 minister that you can come forward safe in the knowledge
 11 that all we're trying to do is protect you. We're not
 12 looking at your documentation or legal status."

13 And that was, I think, probably the most effective
 14 thing to do which is walk the walk, not just talk the
 15 talk.
 16 **Q.** I mean, it's hard to pin down any other examples apart
 17 from that which you've just referred to about your
 18 national radio appearance. You were referred by Counsel
 19 to the Inquiry to your letter, the 8 June letter 2021,
 20 which referred to "No NHS number being required", but
 21 you did need GP registration, and then you set out in
 22 that letter, which we've just had up on screen, there
 23 was -- overseas visitors could have -- be registered as
 24 temporary patients if they were here for over 24 hours
 25 and less than three months, but it's complex and hard to
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1 something we need to accept". So your positions seem to
 2 contradict one another, either --
 3 **LADY HALLETT:** I'm sorry, I'm going to have to stop you,
 4 Ms Naik. I didn't give permission for this question,
 5 I'm afraid.
 6 **MS NAIK:** Well, my Lady, that, we say, is part of the
 7 contradiction between this --
 8 **LADY HALLETT:** And also pointing to this witness that there
 9 may be a conflict between them. I have Mr Zahawi's
 10 evidence. Thank you.
 11 **MS NAIK:** Thank you, my Lady.
 12 **LADY HALLETT:** Thank you very much. That completes the
 13 questions that we have for you, Mr Zahawi. Thank you so
 14 much indeed.
 15 Given your other roles during the pandemic, I'm not
 16 sure I can guarantee we won't ask you to help us again.
 17 I suspect we may already have done, have we, I don't
 18 know, in education or finance --
 19 **THE WITNESS:** Not yet.
 20 **LADY HALLETT:** Okay, well keep your fingers crossed. Thank
 21 you very much for your help.
 22 **THE WITNESS:** Thank you.
 23 (The witness withdrew)
 24 **LADY HALLETT:** I shall break now and return at 3.05.
 25 (2.52 pm)

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

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

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

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

18 **A.** No, I didn't.

19 **Q.** So your -- Ms Badenoch just gave evidence just before
 20 lunch and she said that for people who are undocumented
 21 migrants or illegal immigrants, that their interactions
 22 with the state may be minimal to none, they would be
 23 worried about being deported and she said in terms, "We
 24 cannot adjust our health system, in my view, to
 25 undermine borders and borders securities, that's just
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1
 2 (A short break)
 3 (3.05 pm)
 4 **LADY HALLETT:** I hope you were warned that you would be the
 5 last witness today.
 6 **THE WITNESS:** I was warned, thank you.
 7 **LADY HALLETT:** Yes.
 8 **DAME EMILY LAWSON**
 9 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4**
 10 **MR KEITH:** Could you commence your evidence by giving us
 11 your full name, please.
 12 **A.** My full name is Emily Jane Ruth Lawson.
 13 **Q.** Thank you very much, and thank you for attending today
 14 and also for the provision of your witness statement,
 15 dated 8 August 2024.
 16 Dame Emily, can I start, please, with your role, and
 17 the history of your role, in the NHS.
 18 After a fairly lengthy career in industry, you --
 19 I think you were a director at Morrisons and then the
 20 Chief People Officer at Kingfisher. You were employed
 21 by NHS England from 1 November 2017.
 22 **A.** That's right.
 23 **Q.** As National Director for Transformation and Corporate
 24 Operations. I think you were concerned with the
 25 integration of NHS England and NHS Improvement.
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1 A. Yes, that's right.

2 Q. Then on 1 April 2020, so shortly after the commencement
3 of the government's response to the pandemic, you were
4 made Chief Commercial Officer of NHS England and
5 NHS Improvement, as it then was?

6 A. Yes.

7 Q. Did you, on your appointment as Chief Commercial
8 Officer, immediately become concerned with the other
9 terrible issues concerning and the difficulties of
10 supplying PPE and ventilators, the whole of that supply
11 chain, and procurement and delivery issue?

12 A. Yes, in fact slightly before being confirmed in the
13 role, I got involved in those.

14 Q. During your time as the Chief Commercial Officer,
15 concerned with PPE and ventilators, did you have
16 occasion to work with -- and I want to specifically ask
17 you about them -- a part of the military called the 101
18 logistics battalion?

19 A. I did.

20 Q. We've not heard much, in fact any, about 101 Log, as
21 they were then known. Who are they?

22 A. So, 101 Log is a logistics brigade, as you've said, in
23 the army, led at the time by then
24 Brigadier Phil Prosser, now Major General Phil Prosser,
25 and they were brought in in March 2020 in order to

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1 when you needed extra hands on deck; I think they
2 transformed and set up some of the local vaccination
3 centres. Is that right?

4 A. Yes, some of that was not 101 Log. Some of that was
5 other army groups. But having 101 Log in the
6 vaccination team, like, right in there with us, every
7 day, they performed, you know, many of those functions
8 you said. That operational discipline as well as the
9 specific expertise in supply chain logistics was
10 absolutely foundational to how we ran the programme.

11 Q. I don't wish to intrude into the topic of when and how
12 the military should be invited to assist civilian
13 authorities, it's a bigger issue, but may we presume
14 from what you've said that the military assistance you
15 received in relation to PPE and ventilators, and in
16 relation to vaccination, was of incredible value?

17 A. Yes, invaluable.

18 Q. On 9 November 2020, you were then made national director
19 for Covid vaccine deployment in NHS England. And it's
20 plain from what you say in your statement that that was
21 a hugely important policy role. You were at the head of
22 the pyramid. You also became, did you not, what is
23 known as the Senior Responsible Officer for vaccine
24 deployment and take-up?

25 A. Yes.

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1 support the supply chain issues that were going on with
2 PPE, and worked incredibly closely as part of that
3 integrated team through the summer of 2020. And so when
4 I took over -- sorry, I might have skipped ahead.

5 Q. No, not at all.

6 A. When I took over the vaccine programme at the beginning
7 of November, one of the things I did was to go back
8 using the MACA process.

9 Q. Just stop there. You've just thrown an acronym into the
10 moving parts.

11 A. I apologise.

12 Q. MACA, is that the military assistance to civilian
13 authorities process, by which the military has to be
14 formally invited to help us out when we're in trouble?

15 A. That's exactly right. So that was done through the
16 DHSC. I asked for support again from logistic support
17 from the army; obviously I couldn't specify exactly who
18 or exactly which brigade was sent, and I was obviously
19 delighted, two weeks later, that they decided to send
20 101 Log and Phil Prosser again.

21 Q. Did they help you with, and were they of great
22 importance in relation to, all these issues: supply and
23 logistics; the logistical planning -- because this was
24 an incredibly complex process by which the population of
25 England was to be vaccinated; they acted as vaccinators

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1 Q. We've seen reference to "SRO" elsewhere in the paper.
2 What is the SRO?

3 A. The Senior Responsible Officer is really the person who
4 has to hold everything together. It doesn't mean they
5 are necessarily commanding all the individual pieces
6 every day, and we can hopefully talk about the multiple
7 pieces that came together to help not just, you know,
8 from the NHS, but the Senior Responsible Officer has to
9 be the person that says, "We're doing it this way",
10 hopefully having brought everybody with them, and takes
11 responsibility for executing according to the decisions
12 that ministers and sometimes, in this case, the Prime
13 Minister had made, and being a safe guardian of taxpayer
14 money in terms of doing that at the right
15 value-for-money judgement.

16 Q. And responsibility is key, isn't it? It's about
17 accountability, the Senior Responsible Officer is
18 ultimately the person accountable for the outcome of, in
19 this case, the vaccination programme?

20 A. That's right.

21 Q. All right. And is that why -- and we'll hear witnesses,
22 of course, from Scotland, Wales and Northern Ireland
23 shortly -- they were the respective SROs in each of
24 those nations?

25 A. Yes.

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

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

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

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

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

5 **A.** Yeah.

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

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

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

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

21 **A.** Yes, I would.

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

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

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

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

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

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

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

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

14 **LADY HALLETT:** Thank you.

15 **MR KEITH:** When you became the national director on the
16 4 November -- I think you were asked on 4 November, you
17 were appointed on the 9th?

18 **A.** Yes.

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

22 **A.** Yes.

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

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1 arrangements, the booking system, the recording of
 2 vaccinations individually, and on communications. So
 3 the structure was in place. But what were the three
 4 main challenges in terms of getting it from that
 5 position on 9 November to actually delivering the first
 6 vaccination on 8 December?
 7 **A.** So the week that I took over was the week that Pfizer
 8 data was published saying that the vaccine was
 9 effective. So it went from being a theoretical
 10 possibility to: actually, this was going to happen. And
 11 as you've mentioned, there were lots of component parts
 12 that had been worked through. So the pod system,
 13 et cetera, et cetera. Because of the level of
 14 uncertainty, which actually persisted through November,
 15 the novelty of this vaccine, a lot of final decisions
 16 had yet to be made, in terms of particularly given how
 17 the vaccine might be able to be transported, would have
 18 a major impact on what centres could actually distribute
 19 it, what training people would have to have, et cetera.
 20 All of that remained to be done.
 21 **Q.** So just pausing there, by way of example, Pfizer had to
 22 be kept at minus 70 or thereabouts. It wasn't, of
 23 course, given authority until --
 24 **A.** The 2nd of --
 25 **Q.** -- 2 December, and at the beginning of November, you

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1 the rollout starting at the beginning of December. We
 2 can pay for their deployment and we can bring them on
 3 board?" Or did you have to wait?
 4 **A.** No, we were able to identify and the team had done quite
 5 a lot of work before I arrived on how many staff would
 6 be needed depending on the volume of vaccinations. What
 7 we couldn't do is train them, because obviously what was
 8 going to need to be true about how you dispense this
 9 vaccine wasn't known until the beginning of December,
 10 but the theoretical modelling, the specific roles within
 11 a vaccine centre, for example, that was all created
 12 theoretically around the time that I joined.
 13 **Q.** The third area you identify in your statement as being
 14 particularly challenging was that of process, and you
 15 know where I'm going to. You refer on multiple
 16 occasions to the fact that, to use the terrible
 17 expression, the deployment process had multiple
 18 stakeholders. You appear to have spent a great deal of
 19 time speaking to other people, updating other government
 20 departments, getting input from the DHSC, the Vaccine
 21 Taskforce, the Cabinet Office, the Treasury, Number 10,
 22 DLUHC, I could go on.
 23 Was an optimum process of governance and reporting
 24 to other parts of the government in place when you
 25 joined, or did you have to try to alter the reporting

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1 wouldn't know therefore, what ultimately you'd have to
 2 put into place in order to be able to cope with that
 3 requirement?
 4 **A.** Yes. So we had to develop options, and that novelty,
 5 having never seen this kind of vaccine before and the
 6 fragility of an mRNA vaccine surrounded by its lipid
 7 molecules, meant that until we saw the data from Pfizer,
 8 until MHRA provided that authorisation on the 2nd, we
 9 didn't have clearance to transport it at anything other
 10 than minus 70. Minus 70 is not a standard way to
 11 transport medicine so there wasn't an established supply
 12 chain to do that, and we had the tension between the
 13 cohorts that were most at risk, that JCVI had defined,
 14 so cohort 1, so care home residents and workers, and
 15 then group 2, which was those over 80, and health and
 16 other social care workers, the only place we knew in
 17 mid-November we would be able to get the vaccine to were
 18 hospitals that had minus 70 freezers.
 19 **Q.** We'll come back to that in a moment, and why therefore
 20 you focused on hospitals at the beginning of the
 21 deployment process.
 22 **A.** Yes.
 23 **Q.** In relation to staff, were you enabled to employ at
 24 risk, that is to say, look forward and say, "Well, we're
 25 going to need this number of staff for the purposes of

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1 obligations?
 2 **A.** I needed to alter it. I'd spent the first week doing
 3 what I was asked to do and attending all of the
 4 different meetings, because I wanted to learn, as much
 5 as anything else. And one of the things I noted in
 6 those meetings is everybody would ask me how they could
 7 help. Everybody wanted this to be successful, and I'd
 8 say, "You know, the one thing you can do is cut down on
 9 the number of governance meetings I'm going to", and
 10 everybody would say, "Absolutely, definitely, we should
 11 simplify that, but not mine. My meeting is really
 12 important."
 13 So I got to the end of the week, added up that I had
 14 spent 24 hours just in governance meetings, so not
 15 actually fixing anything. And I said, "No, we need to
 16 streamline this, we need absolutely to be held to
 17 account, this is one of the most important things the
 18 country is doing and it's a lot of taxpayer money, I
 19 totally get that, but can we do it in a way that also
 20 enables us to get stuff done, and put those two needs
 21 together?"
 22 **Q.** You must have reflected why, perhaps in our system of
 23 governance, perhaps in many systems of governance, there
 24 appears to be a need for so many meetings, so many
 25 rolling iterative submissions to be made, so many

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- 1 updates, reports, meetings with stakeholders, actions.
 2 It appears to become a very heavy written process of
 3 bureaucracy imposed on you trying to put something
 4 incredibly valuable and practically important into
 5 place.
- 6 **A.** Yes, and I think there are several things there. One is
 7 just the level of importance. It was so important to
 8 everybody. The other was the funding, as I've
 9 mentioned. Then the other thing is, each of the groups
 10 that you mentioned had a different sometimes overlapping
 11 but different need, right? VTF needed to know that what
 12 they were doing was actually going to happen, the
 13 Cabinet Office had an overall assurance role. Number 10
 14 obviously wanted to make sure this was going to be
 15 successful. The Department of Health had a critical,
 16 you know, policy and oversight role. It wasn't that HMT
 17 needed to take charge of the money, it wasn't that any
 18 of those things was unreasonable, it's that they were
 19 additive rather than complementary and I thought there
 20 was an opportunity to streamline that.
- 21 **Q.** So you did?
- 22 **A.** So -- yes.
- 23 **Q.** You had, within the NHS England structure, for vaccine
 24 deployment, a mission statement --
- 25 **A.** Yes.

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- 1 right decision."
 2 So it was a marshalling cry.
- 3 **Q.** So in a very complex, necessarily, part bureaucratic
 4 system, it gives everybody confidence to make
 5 a decision?
- 6 **A.** Yes.
- 7 **Q.** And it gives them a steer as to what the correct
 8 decision is likely to be?
- 9 **A.** That's right.
- 10 **Q.** All right. You had in this system seven regional
 11 directors of commissioning who were the heads of the
 12 regional teams. Were they responsible in each region
 13 for every aspect of deployment from the technology, the
 14 tech, the data, strategy planning, sites, supply chains,
 15 everything?
- 16 **A.** I just wanted to go back to the mission statement for
 17 a second -- sorry, there's one extra thing --
- 18 **Q.** Yes, of course.
- 19 **A.** -- and then I will answer that question as well. The
 20 other thing was about -- give people something to be
 21 excited about and to feel proud in. I think it's quite
 22 easy in these conversations to think about the things we
 23 can touch and feel, the processes, the reporting,
 24 et cetera, but how people felt about being part of this
 25 was also really important, and I think the mission

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- 1 **Q.** -- and the Inquiry has noted that the Vaccine Taskforce
 2 had a mission statement. They appear to be associated
 3 with successful outcomes. What is the meaning of
 4 a mission statement and why does it help to have
 5 a mission statement?
- 6 **A.** I've referred in my answer just now about the novelty
 7 point that lots of component parts had been worked
 8 through, you know, the people sell, the clinical sell,
 9 everybody was doing good work. But it had got stuck
 10 because when you tried to add those pieces up, it wasn't
 11 clear how to make the right decision, right, that did
 12 vaccinate the right cohorts, that was technically
 13 doable, that was doable in a supply chain. And so
 14 I wanted something that really, in a very synthesised
 15 way, was really clear about what we were for so that
 16 when we put things together, those difficult trade-offs
 17 about this cohort here versus there, whatever, we had a
 18 clear and agreed structure that said, "Well, so long as
 19 it's doing this, it's the right answer."
- 20 So it both enabled different perspectives to come
 21 together and for us to make those trade-offs but also,
 22 I couldn't be in every decision that my team was making
 23 and they were deeply expert people. They needed freedom
 24 to be able to make decisions without me and again, they
 25 could say, "Well, if it's doing this, then it's the

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- 1 statement was helpful for that.
- 2 **Q.** Your long career in HR must have been of great
 3 assistance in that regard?
- 4 **A.** Back to the RDCs. The RDCs were responsible for the
 5 deployment of the programme locally which did mean
 6 things like working with local systems to identify the
 7 right sites for vaccination centres, they were doing,
 8 you know, GP engagement locally that kind of thing.
 9 They weren't responsible for tech development or for,
 10 you know, clinical policy, et cetera. That wasn't
 11 created locally. There were some things that were
 12 created nationally they would then deploy and then some
 13 things they were, sort of, pulling up, if you like, from
 14 the local level.
- 15 **Q.** Would you recommend the use of -- would you recommend
 16 the use of regional directors in the future in the next
 17 pandemic if there's a national vaccination programme,
 18 where each of those directors has more or less full
 19 autonomy within their area?
- 20 **A.** I wouldn't say they had full autonomy within their area;
 21 I would say they played a critical, sort of, corraling
 22 and decision-making function, but it was not the case
 23 that at any point -- I don't think they would have
 24 suggested it to me, but if they'd come to me and said,
 25 "Right, in the northwest we're not going to -- you know,

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1 we're not going to have any vaccination centres", for
 2 example, we just wouldn't have done that.

3 **Q.** All right.

4 **A.** So just to be careful with the language. I absolutely
 5 needed that connection between these single, massive
 6 decisions nationally, and the real intelligence that
 7 said, you know, "If you use that GP site in north
 8 Bristol, you're going to need another one here because
 9 nobody is going to cross that A-road", kind of thing.
 10 But they were the bridge between what we could see
 11 nationally and what they knew, and relationships they
 12 already had and brilliant work that was already ongoing
 13 in some places with individual communities. They
 14 provided the bridge that enabled us to do both.

15 **Q.** So they were more closely connected to their local
 16 communities, they had the local links to directors of
 17 public health, for example, and they knew the best sites
 18 for vaccination as well as how to get in amongst the
 19 local communities in order to improve take-up.

20 **A.** And if they didn't know it themselves, because some
 21 regions are massive, obviously, they had the connections
 22 to the ICSs or the STPs, as they were, and to the LRFs
 23 and could encourage those local discussions to happen.

24 **Q.** One of the core directives, if I may use that word, that
 25 you put into place, was that no one more than -- no one
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1 uptake in areas like Leicester or London, my personal
 2 mantra was three bus stops away from somebody who can
 3 give you a vaccination. It was a starting point to say
 4 that we'd really covered the country. And I was
 5 concerned about areas of rurality which look white on
 6 the map, like there's not many people there, but there
 7 are some people there, and I wanted them to be able to
 8 get a vaccination easily too.

9 **Q.** Vaccination started in hospital hub sites on the
 10 8th with -- was it Mrs Keenan who was vaccinated?

11 **A.** That's right.

12 **Q.** And the evidence before the Inquiry suggests that the
 13 first GP or at least the majority of the GP vaccinations
 14 started on 15 December?

15 **A.** That's right.

16 **Q.** Did you start with hospital hubs because, in terms of
 17 scale, they can deliver more vaccines in a shorter space
 18 of time -- and of course this is a numbers game, you've
 19 got to get as many vaccines out there in the arms as
 20 quickly as you can -- but also the issue of the freezing
 21 of the Pfizer vaccine, to which you've already referred?

22 **A.** That's right. We did not know until 2 December that we
 23 would be able to transport the vaccine at fridge
 24 temperature. We thought we would, so my supply chain
 25 team was in the negotiations with the two pharmaceutical
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1 would be or should be more than 10 miles away from
 2 a vaccination location, excluding, of course, housebound
 3 people.

4 **A.** Yeah.

5 **Q.** Was that a very different approach to that which is
 6 ordinarily used in the context of a routine
 7 immunisation?

8 **A.** Yes, partly because routine immunisations will tend to
 9 take place in primary care, which is, by definition,
 10 more local.

11 **Q.** Because it revolves around GPs and --

12 **A.** Yes.

13 **Q.** -- clinical commissioning groups and primary care
 14 networks, all to do with primary care?

15 **A.** That's right.

16 **LADY HALLETT:** In England?

17 **A.** In England, sorry, yes. It's really important that
 18 pretty much everything I say is about England.
 19 And this programme, we absolutely intended to use
 20 primary care and we -- to get through the volume we
 21 needed, we needed these large-scale centres.
 22 I should add that the 10 miles became very
 23 catchy^{^^}See Louise's note . Obviously, if you're in
 24 a city, 10 miles was sort of irrelevant, (cachey
 25 ^{^^})^{^^}here , and later on, when we were looking at low
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1 grade wholesalers to make sure we could set up that
 2 supply chain, but we didn't know. So, given we that
 3 six days from that point to the first vaccination, which
 4 was agreed with the DAs as well, we needed something
 5 that was definitely doable, and that was hospitals.

6 The second reason was that this was going to be the
 7 first vaccination anywhere in the world outside of
 8 a clinical trial, and we wanted the -- you know, the
 9 infrastructure, the safety sense of a hospital to be the
 10 location for that first week of vaccination, so we could
 11 keep a really close eye on what was happening.

12 **Q.** And at a very high level it's obvious that there was
 13 a move away from early centralisation, in terms of
 14 yourself and NHS England, producing and making sure the
 15 supply chains worked and the vaccines were delivered and
 16 the workforce was available and the vaccinations were
 17 recorded. And away, at the same time, practically, from
 18 hospital hubs and GPs, so primary care networks, to
 19 vaccination centres and community points and pop-ups and
 20 pods and whatever have you.

21 Would it have been possible, was it ever possible,
 22 to have those more granular, specialised delivery sites,
 23 pop-ups, community sites and so on, and mass vaccination
 24 centres, available at the beginning?

25 **A.** We were -- through November, we were -- we had our foot
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1 on the accelerator of all of the modalities because we
 2 wanted to be ready -- not community pharmacy, to be
 3 fair, because it wouldn't have had the scale to start
 4 off with.

5 **Q.** We'll come back to --

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

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

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

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

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

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

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

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

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

22 **A.** Yes.

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

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1 until January.

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

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

10 **A.** Yes.

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

13 **A.** Yes.

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

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

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1 high-priority people?

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

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

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

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1 but we said: you need to work with your communities to
 2 bring the over-eighties in that first week of
 3 vaccination.
 4 **Q.** And I want you, please, to say something about the sheer
 5 complexity of this process. And in terms of logistics,
 6 there was a very significant problem, wasn't there, with
 7 the fact that the Pfizer vaccine couldn't be transported
 8 at a higher temperature than freezer temperature for
 9 more than a particular amount of time?
 10 **A.** That's right.
 11 **Q.** And, indeed, its authorisation required it to have no
 12 more than two journeys, I think --
 13 **A.** Once defrosted, yeah.
 14 **Q.** -- above a certain temperature?
 15 So a normal, average-sized GP surgery, wouldn't have
 16 enough time to split up and use the pizza box of doses
 17 within time before it melted and became unusable. So,
 18 I mean, there were some incredibly complex issues to be
 19 resolved here, weren't there?
 20 **A.** There were, yeah.
 21 **Q.** And in terms of the scale-up, give us some idea, please,
 22 of the speed with which you scaled up from the
 23 52 hospital hubs on 14 December and 116 local
 24 vaccination sites, to the position in the beginning of
 25 February?

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1 available, and then delivered to the right person?
 2 **A.** That's right. And it mattered much more that you'd made
 3 an appointment at the right place for the right vaccine
 4 on the right day, so the supply chain complexity where,
 5 if it's the first dose, at the end of the day if the
 6 GP's got vials left over, they had permission to not
 7 waste it, to vaccinate the next most sensible person.
 8 For a second-dose clinic, it had to be the right people
 9 at the right time receiving the right vaccine, so it's
 10 a more complex delivery challenge.
 11 **Q.** And what was the obligation in terms of the time allowed
 12 to record in GP's records the fact of vaccination in
 13 every individual case?
 14 **A.** In 24 hours into their record.
 15 **Q.** And was that something that was required by the MHRA or
 16 DHSC or --
 17 **A.** It's in the national protocol.
 18 **Q.** It's in the national protocol, the document to which
 19 you've referred?
 20 **A.** Yes.
 21 **Q.** All right. I just want to now turn, please, to some
 22 particularly discrete and individual issues.
 23 On 8 December, two incidents were reported via the
 24 Yellow Card system of adverse reactions to vaccination.
 25 Was that anaphylaxis?

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1 **A.** By the beginning of February we had 1,270-something --
 2 I want to say 1,277, but I might have remembered the
 3 number wrong --
 4 **Q.** 1293.
 5 **A.** Thank you very much. I apologise I didn't get that
 6 right, but I've a lot of numbers in my head -- of which
 7 the majority were local vaccination services, so a mix
 8 of pharmacy and the primary care networks, which we
 9 haven't mentioned, but I assume are somewhere in there,
 10 which were groups of GPs that had been established
 11 earlier, in 2019, to put groups of GPs together at
 12 a certain scale. They became the right scale for
 13 vaccination.
 14 But that included all hospital -- all of our
 15 existing hospitals, so all 256 trusts, including
 16 community trusts, for example, were set up by the end of
 17 the month in order to vaccinate staff in particular --
 18 by the beginning of February, sorry.
 19 **Q.** And was an additional problem that the second dose --
 20 and by February, of course, you've got authorisation for
 21 not just Pfizer but AstraZeneca?
 22 **A.** Yes.
 23 **Q.** The second dose has to be the same as the first dose.
 24 Did that then mean that you had to try to put into place
 25 a system whereby a second dose would be available, kept

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1 **A.** Yes.
 2 **Q.** What happened as a result of the reporting of those two
 3 reactions?
 4 **A.** So those were flagged through the Yellow Card system.
 5 I was notified during the day through the mechanisms,
 6 and MHRA is the authority that's collecting the
 7 pharmacovigilance information and they -- I honestly
 8 can't remember who convened the call, but at 11.30 that
 9 night there was a call with CMO, June Raine, JVT,
 10 myself, Steve Powis, the national medical director,
 11 DHSC, so that the CMOs could look at the information, it
 12 could be considered -- oh, sorry, I can't remember if
 13 Wei Shen was there as well -- to say: was this unusual
 14 or was this expected? Anaphylaxis is a serious but not
 15 unexpected reaction to a vaccine.
 16 And it was in that call that the decision was made
 17 that it was safe to continue the programme, but that we
 18 should introduce the 15-minute wait post-vaccination to
 19 ensure if something was going to happen, it happened on
 20 site, not when somebody was travelling home.
 21 **Q.** And was that significant tweak to the system put into
 22 place from the following day?
 23 **A.** It was incredibly significant and quite lucky, in a way,
 24 that we were still only vaccinating in hospitals, which
 25 are large institutions which have space. If we'd been

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

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

15 **A.** That's right.

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

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

21 **Q.** Please.

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

24 **Q.** ICSs?

25 **A.** Sorry, integrated care systems. So the 42 semi-local
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1 trained; they were actually confident in what they were
2 doing.

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

6 **A.** That's right.

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

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

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

25 But it's INQ000486279 dated 20 November. There we
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1 organisations which oversee the relevant part of the
2 health system and have local relationships with local
3 government, public health, et cetera, and social care.
4 We wanted workforce to be deployed locally. We were not
5 sure at the beginning whether that would give us
6 sufficient scale. Whether there would be enough people
7 in it, and also you might have some places with not
8 enough people. And so we also put in place the national
9 offer with the support of St John Ambulance and the
10 Royal Voluntary Service.

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

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

21 **A.** Yes.

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

23 **A.** Yes. And if they were not previously experienced
24 vaccinators, they also had a period of observation and
25 senior supervision to make sure they weren't just
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1 are. Pfizer. Valid from 20 November 2021. So is this,
2 essentially, the training document for the handling and
3 the delivery of and the vaccination of this vaccine?

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

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

8 **A.** They are, yes.

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

16 **A.** Yes.

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

22 **A.** Yes.

23 **Q.** Over the page to 9. Detailed prescriptive rules
24 concerning assessing the patient who was presenting for
25 vaccination.
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1 A. Yes.

2 Q. Over to page 10. Cautions. So very detailed rules
3 concerning the identification of conditions and
4 reactions in the patient, everything from fainting to
5 reactogenetic (sic) side effects, you know, reddening of
6 the arm, and so on. And then "Very rare reports have
7 been received of Guillain-Barré syndrome" in the middle
8 of the page.

9 Past history of Covid infection, that's 10.

10 Then we can, if we just scroll through 11, 12, 13,
11 14, through to 19, rules on dose, frequency of
12 administration, action to be taken if the individual is
13 excluded, description of treatment, drug interactions,
14 off-label use, adverse reactions, advice, follow-up
15 treatment, special considerations, and finally on
16 page 19, non-responders/immunosuppressed.

17 Do you consider, Dame Emily, that there was any
18 deficiency in the training processes -- obviously you're
19 not physically present in every single training site,
20 but in the general obligation for training, and the
21 degree in which that training was prescribed?

22 A. I don't have any concerns about it and I know it was
23 robust in that one senior clinician notified me that
24 he'd failed the competency assessment the first time
25 around because it was so long since he'd last vaccinated

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1 check up on site to make sure they were using the
2 vaccine they got. It did what it needed to do.

3 It was complex, because the architecture of various
4 different health system, IT systems, which I'm assuming
5 we don't want to go into, is really complex, and there
6 was definitely a gap, which we may come back to, in
7 terms of ethnicity and other data about individuals,
8 which is not held as standard in those systems.

9 Q. The issue of health data generally is extremely complex.

10 A. Yes.

11 Q. And it was in fact the subject of a review, as I know
12 you know, by Professor Cathie Sudlow in November 2024.

13 A. Yes.

14 Q. So last year. And we'll come back to that at the end.
15 But the problem, in essence, is this, isn't it: that
16 there are systems operated by GPs which carry codes,
17 SNOMED codes, that's to say medical characteristics of
18 the patient, but those records are not always as up to
19 date or perhaps as accurate as they might be, and at the
20 same time, there's no GP or general NHS system which
21 includes occupational data, what your work is or what
22 your job is, and also ethnicity? So there's no general
23 obligation to record ethnicity, either at the point of
24 access to NHS services or at the point of recording
25 a vaccination.

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1 and he had to do it again, and he was fine with that.

2 He said, "It's the right thing to do, I want to make
3 sure I can do it properly."

4 Q. Was he really fine?

5 A. I don't know but he told me about it, didn't he? And he
6 did then go on to vaccinate.

7 Q. The NHS England operated a National Immunisation
8 Management Service database called NIMS --

9 A. Yes.

10 Q. -- into which data from another system, NIVS, was
11 placed, along with data from a GP data system called
12 Pinnacle?

13 A. Yes.

14 Q. Do you think that the database which -- the databases
15 which you used were sufficient and effective in terms of
16 trying to exclude too many overlapping and
17 overly-complex databases?

18 A. Having been through it at the time and then gone back
19 through my weekly reports from the tech team from
20 November through to about April in preparation for this,
21 I am sure that we developed something that worked in
22 terms of keeping people safe, making sure there was
23 a record of their vaccination, just in case something
24 happened, that worked for us to record that we were
25 safely delivering the vaccine, that we were able to

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1 So did that make it extremely difficult, when you
2 were asked how can you best reach out into the
3 community, for example, amongst ethnic minority
4 communities, and see what we can do to encourage
5 take-up? You didn't know precisely what degree of
6 ethnic take-up there was of vaccination?

7 A. We didn't have entirely robust data at least initially.
8 It got better as it went on, which we can come back to.
9 Actually, many GPs, not all, had some ethnicity data
10 recorded. It was inconsistent but it wasn't zero. And
11 indeed, we can come back to this, but some GPs did also
12 have a record of whether somebody was a carer or not.
13 As you say, it wasn't mandated. But NHS England had, to
14 some extent, looked ahead at this and already in
15 September 2020 had written to all GPs to say, "Please
16 can you review your holding of this kind of data," not
17 carers, actually, but ethnicity data, and where you've
18 got it, can you make sure it's updated into systems,
19 partly as a reaction to some of the initial events of
20 the pandemic before we got to vaccination.

21 So we were working on it, but you're right, it
22 wasn't complete.

23 Q. But was that letter in part why the process got better
24 and you managed to get better data over time?

25 A. We managed to get better data over time partly because

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

6 **Q.** In sites?

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

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

20 **A.** Yes.

21 **Q.** -- of its output?

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

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

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1 health as much as for anything else.

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

11 **Q.** Is inputting them.

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

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

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

24 **A.** Yes.

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

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

7 **A.** Yeah.

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

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

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

19 **Q.** Please.

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

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1 **A.** Along with everything else, yeah.

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

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

21 **Q.** Thank you, that's very clear.

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

24 **A.** Yes.

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

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1 as to why that was so. Did that present itself as an
 2 extraordinarily complex shift in position, as far as you
 3 were concerned, in terms as changes in supply
 4 allocations, the bookings, the workforce arrangements,
 5 and what to do about people who had already agreed
 6 a second appointment?
 7 **A.** Yes.
 8 **Q.** All right. You were able, within a relatively short
 9 space of time, to completely change the direction of the
 10 system?
 11 **A.** Yes.
 12 **Q.** There were, in the press and elsewhere, and in political
 13 circles, from time to time, criticism of the rates of
 14 vaccination. Did you produce a bar chart which showed
 15 the levels of delivery which you were planning for and
 16 hoping to achieve against actual delivery?
 17 **A.** Yes.
 18 **Q.** Can we have your statement, please, INQ000492335. Thank
 19 you very much. There it is.
 20 We can see there that, as at 19 January, so within,
 21 really, a very short space of time after the first
 22 vaccine delivery, you had planned for and promised
 23 a certain level of delivery. Did you meet that plan and
 24 get the number of actual doses out that you'd promised
 25 you would?

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1 agreements with other parts of government.
 2 **Q.** You mentioned the national booking system earlier.
 3 **A.** Yes.
 4 **Q.** It started, I think, on 9 January. That was its full
 5 operational launch. Why was it not possible to have in
 6 place a national booking system at the point of the
 7 commencement of the vaccination programme on 8 December?
 8 **A.** I mean, partly we didn't think it would be required
 9 earlier. Secondly, this was being built from scratch,
 10 building off of these incredibly complex systems that
 11 don't talk to each other that we've already described.
 12 And it needed to be simple, it needed to be incredibly
 13 user friendly, and it needed to work as a front end, and
 14 then it needed to be pulling data from these multiple
 15 sites about what actual availability they had, which
 16 they had to plan based on what supply we were sending
 17 them and what workforce they had. So this was the
 18 system that was going to have to be the front end to
 19 a lot of complexity underneath the surface.
 20 I was very keen, as I've described earlier, that we
 21 didn't launch it until we knew it was going to work.
 22 And --
 23 **Q.** Because in terms of confidence --
 24 **A.** In terms of confidence --
 25 **Q.** -- collapsed system is disastrous --

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1 **A.** In general we did, I believe. If we looked at this from
 2 a month later, there were some weeks where we were
 3 within shooting distance but not exactly on the number,
 4 which always pained me. And it was obviously subject to
 5 supply fluctuations which did happen over the -- towards
 6 the right-hand side of this chart.
 7 **Q.** Presumably you received updates hourly or at regular
 8 intervals during the course of every single day as to
 9 the rate of vaccination?
 10 **A.** Yes.
 11 **Q.** You must have pored over the charts and the figures --
 12 **A.** Yes.
 13 **Q.** -- the whole time?
 14 **A.** I had a dashboard which was always open on my desk.
 15 **Q.** And presumably you made available to the public and to
 16 the rest of government update figures on levels of
 17 vaccination?
 18 **A.** Yes.
 19 **Q.** Daily, weekly, fortnightly?
 20 **A.** It changed. It started off with a weekly publication.
 21 It moved to daily on 11 January, a Monday. And over
 22 time, we then did an automated feed straight into the
 23 Cabinet Office of certain metrics, so that we weren't
 24 providing the report, they were getting automatic data
 25 updates. And then there were other data sharing

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1 **A.** And also being offered a vaccine booking 100 miles away
 2 from where you lived was just not going to be good for
 3 the programme. It was going to look like it wasn't
 4 accessible, that we hadn't thought about the location.
 5 So we had to work very carefully to put the right
 6 wrapper around that. And despite pushing very hard, my
 7 tech lead, Adrian Stanbury, who started at the beginning
 8 of November, came to me -- I think it was probably like,
 9 the third week of November, and said, "Look, it just
 10 isn't -- I can't push it that hard."
 11 It also had to be clinically safe, there was
 12 a clinical sign-off process as well. So there was
 13 a bunch of stuff to engineer into it.
 14 **Q.** Is there a national booking service for routine or
 15 childhood immunisation?
 16 **A.** There wasn't one, no.
 17 **Q.** So, ordinarily, one would have to wait to receive
 18 a letter or a text saying, "You are being invited to
 19 come in for vaccination or immunisation"?
 20 **A.** Yes. So the school vaccination of flu, for example,
 21 which my son gets, that's how you get it. The Red Book
 22 vaccinations, the ones that happen in early childhood,
 23 tend to be done through routine appointments, where
 24 people are going to their health visitor or GP anyway,
 25 but if people don't come, then, yes, they would get an

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1 invitation that way.

2 **Q.** There was no online ability before 9 January 2021 for
3 anybody to go to an online site and book themselves an
4 immunisation or vaccination?

5 **A.** Certainly not from a national perspective. Individual
6 local systems may have had something I'm not aware of.

7 **Q.** All right. Relationships with devolved administrations.
8 Did the vaccinations commence on the same day in each
9 country?

10 **A.** Yes, for both the first Pfizer dose and the first
11 AstraZeneca dose, on 4 January.

12 **Q.** Was there a close degree of cooperation between yourself
13 and your fellow SROs in the other three nations?

14 **A.** Yes, very much.

15 **Q.** So did the SROs join critical meetings held by the
16 NHS England as well as UK governmental meetings?

17 **A.** Yes, so they were all invited to my operations board,
18 which used to happen every Monday morning, just so they
19 could stay in tune with what we were doing, and
20 challenge it if necessary.

21 **Q.** Public health is a devolved issue.

22 **A.** Yes.

23 **Q.** So it was absolutely within the ability and the right of
24 each nation to decide for itself how to deploy vaccines?

25 **A.** Yes.

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1 physically made available?

2 **A.** I think it was incredibly important for public
3 confidence. I mean, we're not -- well, I don't want to
4 get into a political statement, but -- we are the UK, it
5 was the -- the VTF was operating on behalf of the UK.
6 The countries he had made a decision to buy vaccine
7 together. It was important that the citizens of each
8 country had a similar if not exactly the same experience
9 of being vaccinated or being offered a vaccination.

10 **Q.** You obviously spoke the whole time to your fellow SROs,
11 and you WhatsApped each other frequently.

12 Can we just have INQ000477804, at page 22, please.

13 This is an example of your communications. It
14 happens to be 22 February in the early afternoon, where
15 Naresh Chada from Northern Ireland -- Dr Chada says:

16 "We're having a bad day at the office today. Unpaid
17 carers."

18 Derek Grieve from Scotland:
19 "Been there got the T shirt."

20 Gillian Richardson, from Wales:
21 "Yes agree Derek."

22 Emily Lawson:
23 "We are also using broader definition as ..."
24 People?

25 **A.** Yes.

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1 **Q.** At what point did each nation take over the deployment
2 process? Was it from the arrival of vaccines within the
3 geographical confines of the United Kingdom or was it
4 from the point at which they were delivered to Public
5 Health England warehouses, or what?

6 **A.** So, for England, it was from the PHE warehouse. I think
7 that was -- I'm trying to remember. I think that for --
8 in a couple of instances there was direct vaccine --

9 **Q.** Delivery --

10 **A.** -- supply into one of the countries, but I can't now
11 remember -- I remember the discussion around this, but
12 we --

13 **Q.** Broadly, the taskforce --

14 **A.** We took over from PHE, yeah.

15 **Q.** The taskforce organised procurement --

16 **A.** Yeah.

17 **Q.** -- and delivery into the United Kingdom --

18 **A.** Into the PHE warehouse, yeah.

19 **Q.** -- but there came a point where, physically, each nation
20 would take over --

21 **A.** Yes.

22 **Q.** -- what happened but to the vaccines thereafter.
23 How important was it that even if you weren't in
24 lockstep, each of the four nations broadly agreed on how
25 the vaccine delivery would be prioritised, and

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1 **Q.** "... ppl with carer designation from [Department for
2 Work and Pensions] are more than jcvl."

3 So in relation to almost every aspect of how to
4 apply prioritisation in practice, how to broaden it out
5 operationally, as well as the physical and technological
6 aspects of getting vaccines into everybody's arms, was
7 debated daily between you all?

8 **A.** Yes.

9 **Q.** I don't think we need to spend a great deal of time on
10 it but no doubt there were times of turbulence where you
11 disagreed on particular aspects.

12 By and large, were those points of turbulence
13 induced by events in the media or communications or
14 public sphere, particularly the political sphere, where
15 somebody would say something and then you'd all have to
16 speak to each other and go, "Well, he didn't really mean
17 that", "She said this out of turn", "This the real
18 position"?

19 **A.** Yes.

20 **Q.** All right. By and large, do you think that process of
21 communication between yourselves worked very well?

22 **A.** I think it was incredibly helpful, in the sense we were
23 all in it together, rapid testing of things that were
24 going right or going wrong, and then coming back
25 together formally each week to make actual policy

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

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

8 **A.** Yes.

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

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

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

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

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

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1 opportunity to get people more engaged in healthcare.

2 The real challenge was not having an NHS number.

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

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

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

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

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1 to design it into the systems.

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

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

14 **Q.** Into the?

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

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

20 **A.** Yeah.

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

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1 A. Yes.

2 Q. -- disabled people?

3 A. Yes, there was.

4 Q. And was that adhered to, at least systemically?

5 A. I mean, as far as I knew, and it was certainly -- it was

6 part of the sign-off that the regional directors of

7 commissioning did when they agreed to a site going live

8 was that those conditions had been met.

9 Q. In general terms, in relation to addressing disparities

10 in uptake, is it ever possible to deliver healthcare

11 services to everyone who needs them?

12 A. The short answer to that is no, because we're dealing

13 with societal inequalities which are not under the

14 control of the health service. So we have to do

15 everything we can to come to where people are and design

16 services that work for them, including vaccination.

17 Q. More specifically, in relation to vaccines which are

18 being offered prophylactically, ie to people who aren't

19 ill already, is it ever possible to reach a hundred

20 per cent uptake?

21 A. Not in every segment of the population for every

22 vaccination. We got pretty close to a hundred per cent

23 in the cohorts that felt most at risk, I would say.

24 Q. The uptake in England for two doses for over

25 12-year-olds by 30 June 2022 was 83.7%?

185

1 is a readout, to use the governmental word, or a list of

2 actions from a meeting with the Prime Minister, dated

3 12 January 2021?

4 A. Yes.

5 Q. "The [Prime Minister] asked what is being done to access

6 the harder to reach communities/people, and what more

7 can be done. He asked that the NHS work closely with

8 the [Ministry of Housing]" --

9 LADY HALLETT: Communities.

10 MR KEITH: "[Communities -- thank you -- and Local

11 Government]" --

12 LADY HALLETT: They will keep changing their names.

13 MR KEITH: Yes.

14 "... and local authorities -- thank you -- to

15 provide them with everything they need to maximise

16 rollout and uptake ..."

17 Then there's a reference to Simon Stevens of the

18 NHS.

19 The Prime Minister pressed for data to be made

20 available as soon as possible. The Health Secretary

21 referred to the approach to being able to address

22 disparities in uptake, and the Prime Minister then asked

23 the CMO for his view on the relationship between NHS and

24 the local authorities.

25 Was there any doubt in your mind, that the issue of

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1 A. Yes.

2 Q. Do you think that was a credible outcome?

3 A. I think it was a credible outcome, given the original

4 planning assumptions, before I took over, had been 75%

5 uptake not including children. It doesn't mean that

6 I think there wasn't more we could do. There's always

7 more you can do but I think it was a good outcome.

8 Q. At every administrative or political level, was the

9 issue of disparities in uptake appreciated,

10 acknowledged, and sought to be dealt with?

11 A. Very much so. It was -- I had an equalities team, they

12 were on my leadership team, they were in every

13 discussion. We established the vaccine equalities board

14 which met before we had the vaccine on 1 December and

15 ongoing. When I go back to even before I joined the

16 programme, the programme was engaging, for example, with

17 the British Islamic Medical Association in October to

18 ask about, you know, what would need to be true for

19 people to be able to support the vaccine. So I mean,

20 I won't give you a list because it's in the witness

21 statement.

22 Q. It is.

23 A. But it was ongoing engagement and feedback to see what

24 could we do to keep improving.

25 Q. Could you look, please, at INQ000063195, page 2. This

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1 how to address barriers in uptake in pre-existing

2 disparities, particularly in healthcare, were being

3 addressed at every turn?

4 A. I think on 12 January I would say it was absolutely top

5 of mind. We were holding regular meetings on it. In

6 terms of taking some of the really good example like the

7 one that is cited here in Dorset and scaling them, there

8 was -- we were in the early foothills of doing that and

9 I think what really changed over the -- we did, by the

10 way, make sure that the data was shared by -- we started

11 the full-on data sharing on 15 January, so just at the

12 end of that week. What we were able to do, starting

13 around this time because we weren't so limited by the

14 supply of vaccine and because we had AstraZeneca that

15 was more stable, easier to distribute, came in smaller

16 packages to start off with, just the creativity that

17 local systems could apply to outreach started to really

18 take off.

19 Q. Right.

20 A. And because a lot of the outreach and, sort of,

21 small-scale it takes a lot of people to deliver one

22 vaccine was being used in care homes at this point and

23 then we get towards the end of January and most of that

24 work is completed, most care homes have now had at least

25 one visit, there's then more capacity to do further

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1 engagement and outreach --

2 **Q.** -- to focus on specific communities?

3 **A.** Yes. Plus communities started to come forward more. If

4 you -- you may not remember, but the conversation

5 publicly about the vaccine programme over Christmas and

6 into the New Year wasn't great. It was kind of going to

7 be another example of failure. By the time -- we've

8 shown how much ramp-up you saw in that chart you showed

9 earlier, by the time you get to certainly the third week

10 of January, it's like, oh, this actually might be

11 a success and that encouraged lots of people to say,

12 "I want to help, I want to come forward, I've got this

13 idea" and so we have, for example, the first mosque as

14 a vaccination centre opening, I think on 21 January, the

15 Crawley Bus, which was a local initiative, didn't come

16 from me, at the Hindu temple there, was on 28 January.

17 So just that local engagement and creativity starts to

18 really take off at this point.

19 **Q.** And presumably there were a number of plans and actions

20 put into place to generally increase uptake and to

21 encourage people to come forward. I think Grab-a-Jab,

22 was that one of yours?

23 **A.** Yeah, Grab-a-Jab came from us and was actually carried

24 out by my Chief of Staff, Ellen Graham who put the whole

25 -- well, corralled, putting the website together over

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1 were constantly looking at percentages of uptake across

2 different communities?

3 **A.** Yes.

4 **Q.** And there isn't, we note, any reference here to Gypsy,

5 Roma or Traveller. Would we find figures specifically

6 relating to them specifically anywhere in the NHSE

7 documentation?

8 **A.** No, because it wasn't at the time in the -- what's the

9 right word -- the definitions of how ethnicity data was

10 collected. That's in the process of being updated at

11 the moment.

12 **Q.** So how would you know what the level of uptake was in

13 that community?

14 **A.** We wouldn't have known nationally. It was the kind of

15 thing that we asked local systems to report to us on,

16 those that had local Gypsy, Roma and Traveller

17 populations, we asked for sitrep information to say how

18 that was working.

19 **Q.** And did you get it?

20 **A.** Yes, we would -- I would -- not at a level I'd want to

21 report in national statistics, I don't think the

22 national statistician would think it was robust, but it

23 gave us an indication of the kind of thing that was

24 happening, partly so we could share that with systems

25 that were perhaps further behind.

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1 a weekend in May. Grab-a-Jab was a good example of

2 adjusting to a new cohort. So we now had -- because

3 we'd vaccinated down to, sort of, age 50 by the

4 beginning of April so we were now vaccinating those in

5 their thirties and forties, and they had really

6 different needs from vaccination centres. They were

7 less bothered about appointments, they needed more out

8 of working hours, et cetera. And so Grab-a-Jab was an

9 example of: you're just spontaneously going to decide to

10 have a vaccine this weekend, here's where you can go,

11 and made it more of a social activity, partly because

12 lockdown was ending so we needed to make it even easier

13 for people to get a vaccine because that sense of

14 urgency when you can't see anyone had slightly started

15 to dissipate.

16 **Q.** Let's look, please, at the vaccine uptake plan, this

17 version is 5 February 2021 so around that time.

18 INQ000830899. Did this plan have a number of

19 iterations?

20 **A.** Yes, absolutely.

21 **Q.** If we look at page 3, we can see statistics as at

22 3 February. The proportion of people aged 80 plus who

23 have had their first dose by ethnic group and

24 deprivation. So may we take it from this, and the fact

25 that this is in your core vaccine uptake plan, that you

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1 **Q.** Sorry, do continue.

2 **A.** It was just -- the particular paragraph that you pulled

3 out earlier didn't mention this, but this chart is very

4 good on it. There were real challenges, obviously, with

5 different groups not feeling confident to have a vaccine

6 or not finding our offer convenient at the time, but

7 what this chart shows really clearly on the left-hand

8 side is that there was also an intersection with

9 deprivation, that the more deprived you were, the less

10 likely you were to receive a -- to want a vaccine at

11 this point, even in the white British group at the top,

12 it's lower on the left than it is on the right. So we

13 were conscious of that in terms of where we put the next

14 wave of vaccination sites, for example.

15 **Q.** Page 5, there are references to the work under way, the

16 actions for removing barriers to access and for

17 improving take-up. Presumably these are very broad

18 descriptions, headlines only, of what was actually being

19 done, but we can see reference to resources, funding

20 options, working with national partners, videos,

21 roundtables, communication material, and so on.

22 **A.** Yes.

23 **Q.** In your team, were equality and health -- inequality

24 impact assessments carried out?

25 **A.** Yes.

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1 Q. What were they?
 2 A. They were sort of a policy assessment to make sure that:
 3 if you put this in place, you're not going to -- you've
 4 properly considered the equalities impact and hopefully
 5 made it more positive not more negative.
 6 Q. And was there something called a vaccine equalities
 7 mapping tool to investigate the links in data between
 8 locations and take-up, and a Vaccine Equalities
 9 Committee to try to guide you as to how you could best
 10 improve take-up?
 11 A. Yes.
 12 Q. It's clear that a lot of the work had to be done at
 13 local level. So engagement with local community
 14 leaders, developing a network of trusted voices, local
 15 media and social activity, local ground interventions
 16 from Vaxi Taxis, Hopper buses --
 17 A. Yes.
 18 Q. -- clinics in churches and other faith buildings, and
 19 social venues.
 20 Who in practice was at the local authority end of
 21 all that planning and work? Was it the local
 22 authorities, the administrative structures there? Was
 23 it directors of public health? And how did work in
 24 practice?
 25 A. I would say it was a real mix. So quite a lot of those

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1 fivefold, just in two months. Which showed that if we
 2 found the right engagement and the right ownership in
 3 the local community, and individual communities, it made
 4 all the difference.
 5 Q. Your statement shows that NHS England published videos
 6 featuring people with learning disabilities and autistic
 7 people.
 8 A. Yes.
 9 Q. And the evidence before the tribunal (sic) shows that
 10 there were a number of projects endeavouring to focus on
 11 increasing awareness of vaccination amongst disabled
 12 groups, and also trying to overcome the obvious problems
 13 of accessibility.
 14 One of the problems that appears to have arisen,
 15 however, is that no one appears to have been quite clear
 16 who should be offered a vaccine on account of the fact
 17 that they suffered from a learning disability, because
 18 there was a lack of data as to -- well, the systems for
 19 reporting -- the registers for reporting learning
 20 disability were not entirely accurate, and no one
 21 appears to be quite clear as to what degree of learning
 22 disability one would have to suffer before one would
 23 even get onto the register.
 24 Was that problem circumnavigated in the end or was
 25 it a constant running issue?

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1 initiatives built on existing relationships and outreach
 2 that was going on even before the pandemic. So the
 3 particular strength in the south-west, for example,
 4 where we got a lot of innovation, was because they'd
 5 been doing such strong health inclusion work for
 6 a really long time. So it might have come from -- it
 7 often came from the voluntary sector, so from specialist
 8 groups like Groundswell, for example, on the homeless,
 9 because they knew what was needed by their groups, and
 10 they would either engage locally with people they
 11 already knew, often, in that case, the local authority,
 12 or it might come -- and those local initiatives, as you
 13 say, were critical.
 14 We did also get some national approaches. So the
 15 Bangladesh Caterers Association approached my team
 16 directly to say, in the Bangladeshi community, almost
 17 everybody is connected to somebody in a restaurant, so
 18 why don't --
 19 Q. So you arranged vaccinations in restaurants?
 20 A. Yeah, so why don't we -- and they -- you know, we
 21 provided support, but they cracked on and did it. They
 22 spoke to their own community, and one of the big
 23 successes of this is -- you've just looked at the data
 24 from 3 February -- between 7 February and 7 April, the
 25 uptake in Bangladeshi communities went -- increased

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1 A. Can I say both, in answer to that?
 2 I mean, we were lucky in England that we had a
 3 Learning Disability Register to start off with. I don't
 4 think that was the case in all of the DAs, but -- so we
 5 had a starting point. And it was one of the things,
 6 again, that NHS England wrote to Systems about in the
 7 autumn of 2020 to say: please can you make sure you're
 8 updating this, because -- partly, again, because of the
 9 increased morbidity and mortality among people with
 10 learning disabilities earlier in the pandemic. So we
 11 had a start.
 12 We did a huge amount of engagement with clinicians
 13 and with communities on the SNOMED codes as we went into
 14 cohort 6, because there were potentially thousands of
 15 these individual classifications that needed to be
 16 included --
 17 Q. And they -- in general terms, they were meant to be, and
 18 were anticipated to be, within cohort 4 and cohort 6,
 19 depending on --
 20 A. Yes, depending on --
 21 Q. -- degree of --
 22 A. Yes. And indeed Down's syndrome moved from cohort 6 to
 23 cohort 4 because further data on morbidity came through.
 24 So we did all of the engagement. I absolutely will
 25 say that, you know, that we had the complete register to

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

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

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

14 **A.** Yeah.

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

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

20 **A.** Yes.

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

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

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1 an incredibly detailed report. I think, considering
 2 that alongside Dr Larson's report as well, looking at
 3 hesitancy is really helpful.

4 I think, for some of them, it's worth thinking about
 5 how they would be operationalised. I mean, we are not
 6 short of vaccinators day to day for doing the routine
 7 activity. So one of the things I -- just as one
 8 example, what I tried to reflect in that closing bit of
 9 my personal statement is I recognise it's really hard to
 10 spend taxpayer money on things that you don't need at
 11 the moment. So I think there is an element of -- for
 12 the Treasury and the government, rather than for me, to
 13 think about: (a) is there something it can be doing now
 14 that then enables it to do something different in
 15 a pandemic? And secondly, what level of resilience do
 16 you want to build into obviously not just the health
 17 service, but more broadly? And that's a really
 18 difficult decision.

19 **Q.** You have no trouble at the moment, do you, for finding
 20 enough vaccinators for routine vaccination?

21 **A.** No.

22 **Q.** And the evidence shows you scaled up a huge number of
 23 vaccinators to deal with Covid?

24 **A.** We did. And most -- some of those were volunteers, but
 25 in fact we underused volunteers, right? The -- sorry,

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1 barriers to access.

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

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

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

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

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

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

25 **A.** I absolutely agree with the direction of those, and it's

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1 lots of people volunteered we didn't end up using
 2 because we didn't need them.

3 So I think, for me, the point from -- more broadly
 4 from the pandemic on this, rather -- this particular
 5 issue, rather than just for vaccination, is the energy
 6 that local communities had to get together and help the
 7 community, partly in vaccination, partly in other parts.
 8 The volunteers early on for people who are housebound,
 9 for example, which my dad benefited from.

10 There feels to me there's something there about more
 11 broadly how do we use volunteers, how do we capture that
 12 spirit of actually wanting to help? And that might have
 13 more sort of extended use rather than just for
 14 vaccinators and --

15 **Q.** Do you think there was enough use of health visitors and
 16 pharmacies?

17 **A.** Health visitors, I haven't looked into in detail. So
 18 I think everybody was mobilised locally who wanted to
 19 help. Whether we could have used more of the health
 20 visitor expertise, I'm not sure, perhaps, particularly
 21 with -- with particular parts of the population.

22 Pharmacies, as I said, we didn't start in pharmacy
 23 for scale and complexity reasons, but we really used
 24 pharmacy. By the end of the relevant period there
 25 was -- just under 21% of the Covid vaccines were

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1 delivered in pharmacy, so they kept going. And in the
2 recent campaign, the winter campaign for flu and Covid,
3 they did over 40% of the Covid vaccination, so the role
4 that pharmacy plays in vaccination, particularly in
5 areas of -- which are underserved by both primary and
6 secondary care is absolutely vital.

7 There is one other one I just wanted to quickly
8 react to, which was the communications one. I think
9 national messaging was really important, I think there
10 were some really powerful campaigns, but for people who
11 are not inclined to trust government or, you know, big
12 organisations, actually trusted voices, somebody you
13 know or somebody who has similar background to you, who
14 is speaking in a different language perhaps, preferably
15 who is also clinically qualified -- it's quite
16 specific -- but trusted voices were that much more
17 powerful when people were already concerned, and I think
18 we should make sure that's part of that overall, sort
19 of, broadcast strategy. Some messages are better
20 delivered in a quiet conversation that maybe doesn't end
21 up with vaccination but does end up with you feeling
22 more confident overall. And those 3Cs of confidence,
23 complacency and convenience that were built into every
24 part of the programme, I think they're very well
25 reflected in the expert report, which is brilliant.

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1 safety concerns about some vaccination centres, for
2 example them being very crowded with poor ventilation.

3 Given the particular issues for clinically
4 vulnerable people who were being asked to travel long
5 distances, why were strategies not developed for
6 delivering the vaccine at home to these high-risk groups
7 who may not necessarily have been housebound or
8 physically disabled?

9 **A.** Thank you. So I hope it is clear from other parts of
10 the statement and from the service specifications for
11 all the different modalities that the centres being safe
12 was a really critical part of delivery and they were
13 expected to uphold, at the time, masking and social
14 distancing. And that as I said, that would have been
15 part of the sign-off process that they were doing that.
16 It's equally clear from the individual experiences
17 you're recounting that that wasn't everybody's
18 experience which is obviously, you know, incredibly
19 disappointing.

20 I would have expected those kind of issues to be
21 reported in the local system and then managed locally,
22 and if they were consistent, then to have come back to
23 me and don't recall them coming back to us nationally.
24 A few individual complaints did, but not those kind.

25 So that doesn't make it, you know, okay for the
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1 **MR KEITH:** Thank you very much.

2 **LADY HALLETT:** Thank you, Mr Keith.

3 Ms Douglas, I think you have a few questions.

4 **Questions from MS DOUGLAS**

5 **MS DOUGLAS:** Thank you.

6 Can you hear me okay, Dame Emily?

7 **A.** Yes.

8 **Q.** Thank you. I act on behalf of Clinically Vulnerable
9 Families who act in the interests of the clinically
10 vulnerable, the extremely clinically vulnerable and the
11 immunosuppressed, and I have just one question and it
12 relates to models of vaccine delivery. We've heard your
13 evidence earlier about the efforts made to get the
14 vaccine to over-80-year-olds and people in care homes in
15 the early weeks of the rollout, and you've described, at
16 paragraph 202 of your statement, the steps taken by
17 NHS England to ensure that certain housebound and
18 disabled patients were able to receive the vaccine.

19 Many CVF members in fact had to travel significant
20 distances to vaccination centres, and a pressing
21 concern, particularly for those who had been shielding
22 up until then, was the risk of contracting Covid-19
23 associated from travelling to be vaccinated, either from
24 public transport or when being driven by someone in the
25 close confines of a car. CVF's members also report

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1 people that experienced that but I don't think it was
2 a wide problem. I think centres were very conscious of
3 being careful about social distancing and I remember one
4 example in Newcastle where they had people queueing
5 outside in the snow, which also worried me because
6 people had come too early for their vaccination, so
7 I think we had lots of different needs that were being
8 juggled operationally. It was part of the system and it
9 was part of the oversight, the safety of the site.

10 You also talked about travel. We expected
11 clinically extremely vulnerable, so I think we're
12 particularly talking about cohort 4 rather than
13 cohort 6, let's say, yes, that they would largely be
14 vaccinated by their GP because their GP was holding the
15 Shielding List, and indeed local authorities would have
16 been also aware of who they were.

17 So that should have dealt with some of the local
18 travel issues and I would have expected their GP to be
19 close to them. It may well be that in a few places the
20 local PCN perhaps wasn't vaccinating at the time. We
21 would have always wanted to work to make it convenient.

22 The definition of housebound was a clinical
23 definition that the programme itself didn't develop. It
24 was important to limit it, though, operationally because
25 obviously it was incredibly low volume so we -- given

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1 that we needed to reach a whole cohort nationally, we
2 had to balance individual needs with the local
3 population needs. I thought we struck the right balance
4 but clearly for a few individuals that didn't manifest.

5 **LADY HALLETT:** Thank you, Ms Douglas.

6 **MS DOUGLAS:** Thank you.

7 **LADY HALLETT:** Ms Beattie, who is sat over there.

8 **Questions from MS BEATTIE**

9 **MS BEATTIE:** Thank you, I ask questions on behalf of
10 Disabled People's Organisations.

11 In late January 2021, you authored a discussion
12 paper for the NHS England and NHS Improvement board
13 meetings about the progress of the vaccine deployment
14 programme.

15 Could we bring that up on screen, please. It's
16 INQ000414427.

17 **LADY HALLETT:** Could you get on with the question while it
18 comes up.

19 **MS BEATTIE:** Yes, certainly.

20 At page 3 of that document, at paragraph 13, you
21 wrote that:

22 "The NHS is providing local authorities with
23 visibility on uptake in their communities so they can
24 target engagement appropriately."

25 Mr Steven Russell in his corporate statement for
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1 disability by impairment type, for example?

2 **A.** Outside of learning disability, no, I don't think so.

3 **Q.** And so given that disability data was not recorded, how
4 did local authorities have visibility of vaccine uptake
5 by disabled people in their area so that they could
6 target engagement appropriately?

7 **A.** So I am not aware that local authorities would have had
8 such a data collection. What did happen, as we
9 discussed with the Gypsy, Roma and Traveller groups,
10 earlier, where that's not in the data collection from
11 your GP record and therefore we can't use it to
12 correlate with your vaccination data, is that local
13 engagement, particularly with voluntary and community
14 groups, would enable local authorities to say, "Well,
15 we've got a particular gap here." They wouldn't have
16 had precise, it's 15% of disabled people, for example,
17 but they would have known, you know, there is a problem
18 with access in that the local bus route doesn't take
19 appropriate support in order for people to get on,
20 et cetera. That is something that local authorities
21 would have been able to do through relationships,
22 through their local directors of public health, and
23 through the overall uptake information.

24 **Q.** But it's right, isn't it, that the National Immunisation
25 Management System was commissioned in 2020, as a new

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1 NHS England confirms that overall data about disabled
2 people is not available from the National Immunisation
3 Management System. So given that disability data was
4 not recorded, how did local authorities have visibility
5 of vaccine uptake by disabled people in their area, so
6 that they could target engagement appropriately?

7 **A.** So this line 13 is the one from my board paper, is that
8 right?

9 **Q.** Yes, and I apologise that it hasn't come up.

10 **A.** Yes, that's fine. I've got it now. So I think you're
11 partly asking a question about data and data recording
12 about disability, is that right, and about engagement
13 with local authorities on that?

14 **Q.** Well, yes, the question is that we've been told that the
15 National Immunisation Management System did not record
16 disability data, which we understand to mean there was
17 no disability data recorded other than perhaps the CEV
18 code about when someone came for vaccination; is that
19 right?

20 **A.** It would have contained any information that was in the
21 SNOMED codes for cohort 6, as well, so some learning
22 disability, for example, but not physical disability
23 which wasn't part of the extra morbidity and mortality
24 as defined by the JCVI, yes.

25 **Q.** And it wouldn't have contained any disaggregated data on
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1 system -- (overspeaking) --

2 **A.** In the summer of 2020, yes, it was.

3 **Q.** And is there any reason that disability data could not
4 have been collected at the point of vaccination in that
5 system?

6 **A.** I don't know, and I'm happy to write back to the Inquiry
7 on this, whether there are definitional codes already in
8 NHS systems which NIMS, the immunisation management
9 system would have had to draw on, like, for example,
10 Gypsy, Roma and Traveller is not in the dictionary, or
11 wasn't in the 2001 census definition. So I don't know
12 if there is something to build off or if it would have
13 to be a new data collection but I'm really happy to
14 write back and say exactly what the status was and what
15 the work is ongoing to address that.

16 **Q.** So if there is, indeed, a gap, which is what we
17 understand the evidence is, would you agree, then, that
18 that's a necessary improvement that should be made to
19 fill that gap?

20 **A.** Yes, depending on -- recognising it might take a fair
21 amount of work to get to agreement on the definitions in
22 the first place, being able to look at that data, I'm
23 sure is something local authorities would -- would find
24 very helpful in terms of commissioning of services, for
25 example.

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1 **MS BEATTIE:** Thank you, my Lady.
 2 **LADY HALLETT:** Thank you, Ms Beattie. Very grateful.
 3 That completes the questions we have for you,
 4 Dame Emily. I'm sure we're all extremely grateful to
 5 you for the work that you did during the pandemic and
 6 for assisting the Inquiry, both in your statement and
 7 your evidence today. You were obviously very measured
 8 in your responses. I was very tempted to ask you about
 9 the difference between the private sector and the Civil
 10 Service but I won't, given the time.
 11 Thank you very much indeed for all your help.
 12 **THE WITNESS:** Thank you very much.
 13 (The witness withdrew)
 14 **LADY HALLETT:** 10.00 tomorrow.
 15 **(4.45 pm)**
 16 **(The hearing adjourned until 10.00 am the following day)**
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62/22 89/5 114/12	36/1 38/12 44/23 46/9	193/23 194/5 197/4	61/19 62/5 64/19	157/20 170/7 172/1
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whole-virus [1]	100/18 101/23 102/20	183/1 183/6	83/17 86/22 87/16	26/22 26/25 27/16
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