Tuesday, 28 January 2025

(10.00 am)

LADY HALLETT: Mr Keith.

MR KEITH: Good morning, my Lady. The first witness today is Derek Grieve.

MR DEREK GRIEVE (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4

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

A. Yeah, my name is Derek Grieve.

Q. Thank you very much, Mr Grieve. Thank you for attending today and also for the provision of your witness statement dated 4 October 2024.

I'd like to start, please, by asking you some questions about the Health Protection Division in the Scottish Government. You became head of that division on, I think, temporary promotion to a senior civil servant on 1 May 2019. Did your position then become permanent in August 2021?

A. It did.

Q. And what is the Health Protection Division concerned with, in general terms?

A. So it covers a range of policies. That includes screening, vaccination, some other activities such as burial and cremations, and a range of other policy areas

that relate to health protection itself.

Q. It is plainly concerned with public health and, in particular, the protection disease; is that right?

A. Yes, that's correct.

Q. How does it work with Public Health Scotland?

A. So Public Health Scotland weren't in existence when I took that division -- when I headed that division, but there's a very close relationship between government and the clinical leads that -- of individuals that became Public Health Scotland, so I had regular contact with clinical leads and the organisational leads themselves.

Q. When you say "clinical leads", do you mean the clinicians inside what became Public Health Scotland as well as chief pharmaceutical officers, chief medical officers?

A. Within government, yes.

Q. Within government.

Between January to June 2020, did you have policy responsibility for the initial response to the emerging pandemic?

A. I did indeed.

Q. Who did you report to?

A. So my director was Richard Foggo, the Director for Population Health, of which my division sat within his directorate.

Q. So he was concerned with population health?

A. That's correct.

Q. And presumably your division, Health Protection, was just one of the divisions for which he was then responsible?

A. That's correct.

Q. Presumably then you worked very closely with ministers in the Scottish Government?

A. I did indeed.

Q. From the First Minister, Nicola Sturgeon, to the Cabinet Secretary for Health and Sport, Jeane Freeman MSP, Humza Yousaf MSP -- I think he was Cabinet Secretary for Health and Social Care after Jeane Freeman?

A. That's right.

Q. And also the ministers for public health as well?

A. Yes, that's right.

Q. Then did there come a time when you were asked to establish and lead a Covid-19 vaccines policy division?

A. I was indeed. That was in June 2020.

Q. And who asked you to do that?

A. It was my director, Richard Foggo. He was also joined by another director within government, Donna Bell.

Q. And it's obvious, you were asked to do that as part of the Scottish Government's preparations for the prospective vaccination rollout?

A. That's correct.

Q. Essentially, you were the Senior Responsible Officer?

A. That's right.

Q. Is that a formal position or is that a more informal recognition of the importance of your role in the vaccination programme?

A. It's more the latter.

Q. As Senior Responsible Officer, did you remain accountable to other officials in the Scottish Government, and ultimately to ministers?

A. Yes, I viewed my role as an SRO as an extension of being able to provide ministers with assurance that the policies were being operationalised and delivered.

Q. And then eventually, did all the vaccination-related policy, was it all brought within a single directorate, I think later in February 2021?

A. That's correct.

Q. Within your functions and responsibilities, were you concerned with the setting up of a programme, the programme for vaccination, of both Covid and influenza?

A. Yes, we took a decision to include flu during 2020 because we were concerned collectively -- and that includes ministers -- of the impact of whether there -- if there was a bad seasonal -- flu season in late 2020 to coincide with an increase in Covid cases.

Q. Presumably, at the beginning of 2020 there was already in existence an immunisation programme and the structure for population-level or at least a sectoral-level immunisation for childhood immunisation and influenza?
A. There was but during 2020 -- during the winter of 2020 of course we had a number of restrictions because of Covid so we delivered the flu programme in a different way.
Q. To what extent did having a flu vaccine and a Covid-19 vaccine programme together take pressure off existing primary care structures?
A. Well, I think it did. It allowed primary care -- and I mean that in a wider sense, primary care, GPs, pharmacies, others, to focus on only the work they can do. But it also gave us a chance to test and, in some cases, stress-test what would later become an approach to a mass vaccination programme.
Q. You say in your statement that the approach of combining flu and Covid vaccination wasn't, to use your words, universally welcomed by all vaccine leads in the health boards -- we'll come in a moment to what the health boards consist of -- but why do you think it wasn't universally welcomed?
A. So I don't think it was the principle of combining the flu and Covid that wasn't universally welcomed, I think

it was the -- this was the first approach we'd taken where there was a nationally led programme and up until that point delivery had been completely devolved to individual health boards. This was the first time where it was a nationally led programme and the programme described itself as being "nationally led but locally delivered". This was the first -- that was the thing, I think, that caused a little bit of tension initially.
Q. And within your division, was there, or did you divide up the functions in your division between a programme board and a delivery group?
A. So in terms of the governance of that programme, yes, I created a programme board and that was supported by a delivery group which reported into that programme board.
Q. And did the programme board consist of, I suppose the clinicians, the scientists, so the Chief Scientist, Chief Pharmacist, Public Health Scotland, CMO, CNO, and members of the Scottish Government Health Protection Division?
A. Yes.
Q. And do we take it that the division became responsible for the setting up of all aspects of the vaccination programme, so supply chain, the vaccination sites, communications and engagement to drive take-up,

operations and security, governance, and the workforce?
A. The programme did, yes.
Q. Let's look, please, at your statement, INQ000474396, at page 43, where you set out references to a number of the other bodies in the Scottish Government and in Scotland which were concerned with the vaccination programme.
If we just go back to page 43, please, and scroll out. Thank you very much.
We can see in paragraph 108 that the:
"... NHS Health Boards led on the delivery and roll out of the Covid-19 and seasonal flu vaccines ..."
We'll look at NHS health boards in a moment, in greater detail but essentially, they are regional health boards within the NHS which deliver primary care.
A. They deliver healthcare.
Q. Healthcare. And are these health boards the result of the transformation process which had taken place and was still going on within Scottish Government over the previous two or three years?
A. In relation to vaccination?
Q. No, in relation to their constitution and set-up. There was a transformation programme, we understand, which led to the creation of NHS health boards?
A. Absolutely. The fact -- the transformation -- so the health boards have been in place for a number of years.

The transformation programme I think you're referring to was the Vaccination Transformation Programme that hadn't been fully implemented at the start of the pandemic but the approach we took through the flu vaccination and Covid vaccination programme was predicated on that, the models underpinned by the Vaccination Transformation Programme.
Q. And what, in essence, was the transformation process? What did it do, in practical terms?
A. So the vaccination -- I'll use the acronym, the VTP was designed to modernise vaccination so that included, for example, developing new IT systems, having a new tracking system and call up system for all individuals for all immunisation activity, and importantly, removing vaccinations from GPs and that was part of the, I think, 2018 GP contract that was agreed, so that, at its heart, it was designed to do that.
Q. All right.
Mr Grieve, will you just slow down a little bit, we're going quite fast.
A. Apologies.
Q. No fault at all, but if you just go a bit slower, it's easier for the stenographer.
And then if we can just scroll out and look down further towards the bottom of the page, we can see there

you refer to the role that national NHS boards played in the flu vaccination/Covid vaccination programme. There's a reference there to NHS National Service Scotland which provided logistical support, programme management support, a vaccine helpline, an online digital tool, and if we go back out, NHS 24. Were they concerned with developing and managing vaccine information pages online?

A. Yeah.

Q. And over the page, NHS National Education Scotland for supporting material and creating and developing the digital platform.

And then Public Health Scotland, to which you've already referred, it provided patient leaflets, posters, digital assets, and the clinical governance group.

A. Yeah.

Q. So there were a number of moving parts, and to a large extent, all parts of the public health bodies in Scotland were involved?

A. Yes.

LADY HALLETT: Mr Keith, are you going back to the question of removing GPs from the vaccination --

MR KEITH: Yes.

LADY HALLETT: You are going back to that?

MR KEITH: We'll come on to the structure in a moment. Yes,

indeed.

LADY HALLETT: Thank you.

MR KEITH: The paperwork or the material before the Inquiry suggests, and in fact, my Lady, we'll go straight on to this topic. The material before the Inquiry tends to suggest that at the beginning of the vaccination programme there was a more limited use of GPs and community pharmacies; is that right?

A. That's correct.

Q. To what extent did GPs expect to be part of the vaccination programme from the start, and to what extent -- or why was it that they weren't as involved at the beginning as they ultimately perhaps proved to be, particularly in the case of rural areas in the Highlands and islands?

A. Okay, well, at the very start of the vaccine rollout, of course, we were prioritising the most vulnerable, and we did use GPs to identify and vaccinate the over-80 vulnerable who were at home, so we did use GPs for that purpose. But the priority group at that time was the very elderly and the care homes. And as I think has been mentioned before, supply was a constraining factor, and there was a huge amount of logistical challenges associated with supply.

In short, we didn't use primary care -- be it

pharmacists or GPs -- extensively, because some of the constraints with the vaccine, how it was delivered, they came in large trays, they had a huge amount of complexity around handling and transfer, and in Scotland we didn't have GP surgeries that had the breadth of coverage that we felt confident could use the vaccines without high level of wastage.

Because supply was so constrained, the programme was -- had a laser-like focus on ensuring we didn't waste vaccine wherever possible, so we -- that drove us to a model which protected as much as possible all vaccine supplies that we received.

Q. And can you just explain to us what the health boards therefore actually consisted of? Is it an administrative structure responsible for the provision of primary care, which includes within its remit GPs and other healthcare systems or delivery systems, but which then became responsible for identifying and running the sites in which vaccines were delivered? Is that the nub of it?

A. Pretty much. So it varied, but the structure in Scotland has something called integrated joint boards, which is overseen both by the health board and the local authority. So some health boards devolved responsibility through these integrated joint boards,

but ultimately the health board retained overall oversight of the activity in their area.

Q. And therefore the GP system is just one part of these integrated health boards?

A. Exactly.

Q. Right. And I think we've seen in the paperwork as well that one of the advantages of having the health board system that you have in Scotland is that directors of public health are ex officio members of the integrated health board, so you have a public health element being input into the system at that level?

A. Exactly right.

Q. And in essence, therefore, what the health boards did was identify and set up a large number of vaccination sites across Scotland. Less so, perhaps in the more rural areas. But they were sites that weren't run by GPs themselves?

A. That's correct. Although it's important to say that although we didn't use GPs in their surgeries, we did extend the offer for GPs and pharmacists and many other primary care clinicians, such as dentists and others, to be part of the vaccine workforce, often within vaccination centres.

Q. Many of these issues are reflected in a policy document which I want you, please, to look at and identify for

us. We're not quite sure of its etymology.
INQ000499465.
Mr Grieve, this is a document which talks about deployment of Covid-19 vaccines to care homes, and it talks about the position in England and over the page, on page 2, in Scotland, and it says under the heading "Assessment":
"In Scotland, we are not calling forward over ... 80 year olds for vaccination in this first phase, with the exception of those who are care home residents or long stay inpatients."
And there's a reference to 950 primary care sites as having been set up and then references to why you've adopted the approach you did and also, the impact on GPs in England, and you draw a contrast -- or somebody draws a contrast with the position in England.
We assess that this must be a document dated around mid-December because it talks about the imminent rollout of vaccines through GPs in England and that started on 15 December. Do you recognise this document?
A. I actually don't. I recognise the content of it but, as you've alluded to, I'm not sure who it's from or who the recommendation is being made to, if it's programme or ministers, but I do recognise the content of it.
Q. Is what it says about the number of reasons for the

approach that was adopted in Scotland correct? So there were difficulties with packing down and supplying vaccines to GP practices, that there wasn't a primary care network equivalent arrangement in Scotland as there is in England, and none of the GP practices in Scotland had the ability to use the whole -- I'm going to say pizza box -- the whole 975 doses within the very limited amount of time that the Pfizer vaccine in particular had to be used within?
A. That's correct, and that's what I was referring to about the wastage.
LADY HALLETT: What does "pack down" mean in that context?
MR KEITH: Divide.
LADY HALLETT: Thank you.
MR KEITH: My Lady, that's not my word.
You, importantly, say -- or somebody says:
"There are more over 80 year olds than we have vaccine for and so if we were to call this group forward we would raise expectations that we then cannot meet ..."
A. I think as we alluded to, at the very start of the programme the supply was limited and we didn't have a high level of confidence that we'd ramp up very quickly, and therefore we literally couldn't have vaccinated all the 80-year-olds on the first day of the

programme starting. So we had to be relatively measured in our plans, and pragmatic, recognising that, for many of these over 80-year-olds, we'd need to give them time to make arrangements, many would have to be supported to come to get vaccinated, and that took a bit of time.
And equally, because we didn't have the supply -- sorry, I'm maybe speaking a bit fast so I will slow down.
Q. Slow down, Mr Grieve.
A. So the -- that allowed us a bit of time to ensure that our deployment plans aligned with our expectations on supply.
Q. The expert evidence commissioned by the Inquiry from Dr Kasstan-Dabush and Dr Chantler, states that, by comparison to the rest of the United Kingdom, you delivered the Pfizer vaccine, in particular, quicker into care homes than any other part, and that you had a policy of vaccinating care home staff on the same visit as you vaccinated the residents.
A. That's correct.
Q. So you got the numbers in care homes up very high very quickly, relatively speaking?
A. Yes, we did, but that wasn't the objective. The reason we managed to do that was because the Chief Pharmaceutical Officer had found an exemption within the Medicines Act that allowed us to pack down or break down

these pizza boxes, as you've alluded to, under supervision of an NHS pharmacist. But because of the licence restrictions on Pfizer, the vaccine had to be administered by an NHS employee, and that's why we couldn't use care home nurses, but it did allow us to take the vaccine to care homes.
But it was a very pragmatic decision if we were -- given we knew the care home workers were part of the priority group, if you're in the care home and have the vaccine there anyway, in order to, one, use that vaccine and ensure there's minimum wastage, it made sense to offer the vaccine at the same time to staff as well as residents.
Q. Was that not happening in England? Do you know?
A. I honestly can't comment on what was happening in England.
Q. All right. And then, in a general sense, when Delta became the dominant strain of SARS-CoV-2, were there changes in the rollout approach? Presumably by that time, of course, you'd worked your way through the priority list and everybody who was on that priority list had at least been offered a vaccine?
A. I mean, to be perfectly candid, there -- I can't recall a time there wasn't changes to the programme. The evidence and advice from JCVI and MHRA required the

programme to pivot and change constantly through the time I was on it.

Q. Latterly, there were more mobile units, delivery of vaccines at agricultural workplaces and shopping centres and education centres. So there was a more tailored, perhaps a more specific, but a more varied way --

A. Yeah.

Q. -- of delivering vaccines as time rolled on?

A. Exactly.

Q. And give us some idea, please, Mr Grieve of the degree of scale-up between mid-December 2020 and February/March 2021, by which time it was expected that the vast majority of the priority recipients would be offered a vaccine.

A. Yes.

Q. And indeed, you met that plan.

A. Yes, so we had published a vaccine deployment plan in September with what we thought was going to be our first autumn-winter programme that combined Covid and flu vaccines, but you're right, that all changed when Omicron became present. And the JCVI offered advice, and the programme had to massively scale up to deliver, and there was -- a whole range of activity had to happen almost overnight. That included both new vaccination centres, increasing the opening hours of vaccination

centres, the staff, the workforce that went with it, reducing the 15-minute observation time -- we reduced that to five minutes and that allowed to us increase the flow through vaccination centres, and -- as well as a huge marketing campaign, which I think we called "Boosted by the Bells", I think, and that enabled us -- I'll just check -- I think we got 2.9 million people vaccinated before the bells through that increased activity.

Q. By comparison to a routine immunisation programme where there might be, I suppose, a passage of or an elapse of time measured in months, years, perhaps, between the initial planning and the actual rollout, how compressed was the time between the beginning of the planning for the Covid-19 vaccination programme and the first delivery of a vaccine?

A. It was incredibly compressed, and although I'm here today, I want to put on record my huge appreciation for the team that came together, the organisations you've mentioned, as well as working in those organisations, we had embedded staff from these organisations. And they pivoted on a pin. Much of the activity had to be taken in parallel, and we couldn't always provide some of that work in advance of JCVI opining on a matter. So as soon as we had a sense of what JCVI were likely to announce,

that, a whole range of activity was initiated, everything from working out how we identify individuals, drafting protocols that were going to be used, developing training material for the workforce, developing patient safety material, and we managed to condense that timeline between receiving JCVI advice and starting to vaccinate to, sometimes, seven days. And that was phenomenal by the team involved in that.

Q. In what state were the relevant data systems? Presumably there was an obligation to record, in health board records, the fact of each individual vaccination within a certain amount of time. Was it 24 hours?

A. So, in the main it was realtime, the Vaccination Management Tool was a digital tool used by vaccinators on site, and it was linked directly so as soon as the clinician sat down in front of the patient and entered the records it was uploaded immediately, but if, for any reason, the IT systems went down, then we'd, generally speaking, at the end of that working day, the team would upload the record. So it was less than 24 hours.

Q. At the commencement of this vast piece of work, was ethnicity of the patient, of the recipient of the vaccine, routinely recorded or anticipated that it would be routinely recorded in the data programme?

A. It wasn't at the very start of the programme, but we did

develop that dataset, and added -- and I think it went live in November 2021.

Q. And do you know why it wasn't until November 2021 that you were able to record ethnicity in the take-up data system?

A. So we identified the gap quite early on, and I think as I said in my statement, we established that -- an equalities division within the Scottish Government quite early on in the programme, but the IT systems I'm referring to were built for a purpose and had to continually change for the programme with lots of different dose schedules, different vaccines, different call-up arrangements, and the IT colleagues who were developing those systems were cautioning against the risk of these systems being adapted to the point that they might fall over. So it just took time to get those fields added.

It would have been better to do that sooner but it was incredibly complex, but now it's embedded and is a mainstay of the programme itself.

Q. What was the complexity? I mean, presumably the system had to be largely built from scratch, there hadn't been a population-level vaccination programme before, why wasn't it just a question of putting in a code reflecting ethnicity into the system when the data was

inputted? I'm sure it's a great deal more complex than that, but could you explain why it couldn't be done sooner than it was, in the event, done?
A. Well, I'm not an IT expert. I rely on the experts that tell me how difficult it is. I'm told by the colleagues that were leading on this work, it's not as simple as that, because, as I alluded to, the initial programme was built for one vaccine with a particular dose schedule, a call-up arrangement, and we were constantly, through that early part of 2021 changing that system as new information became available, for example not providing AstraZeneca to a particular age cohort. The system had to reflect all of that so we didn't inadvertently call up people that we didn't want to call up and give them the wrong type of vaccine.
Q. All right. And may we take it that the inclusion of ethnicity as a particular code in the data system was of great assistance because, of course, it allowed you a far better understanding of rates of take-up --
A. Yeah.
Q. -- amongst ethnic minority communities?
A. Exactly. Not just at a national level but at a board level, and even at a community level and a clinic level, we could see, as I've said, almost in realtime what uptake was like in different groups and it allowed us,

both the national team and the local team, to adjust. And that could mean our messaging, it could mean our comms activity. And we could see if some of that activity was having an impact in vaccination rates the following day, for example.
Q. Next time, of course, the system will already have been in operation. No doubt it will be a great deal easier, in the face of the next pandemic, to set up a recording of vaccination data system which includes all the codes and all the information that you would wish it to have to make the system work more effectively?
A. Yes, and I think as I alluded to in my statement, this was all being built at pace and it's credit to the team that they managed to do that but yes, you're right, there's lots of lessons we've learned and, as I've alluded to, now ethnicity is a standard cell in the recording of vaccination data.
Q. Funding, Mr Grieve. The Inquiry is aware that prior to the deployment of vaccines, it was agreed that vaccines would be physically allocated using what's known as the Barnett formula, which is the process by which public monies are divided between all the nations in the United Kingdom. And Scotland would therefore have access to, I think it was 8.28% of any Covid vaccines that would end up being procured by the United Kingdom

Government.
Did that funding division work, bearing in mind the demographic particulars of Scotland? So for example, it wouldn't necessarily reflect perhaps in one nation rather than another a greater number of more vulnerable elderly people who needed the vaccine quicker?
A. If there was time, if we had the time to do full population-level modelling and base our supply forecasts on that, then that would have been a preferable model but the Barnett formula, using the Barnett formula itself, I can't recall an instance where we felt our deployment was having to be slowed down because of our allocation of available vaccines. It's probably important to say that it would have been a problem if BEIS and the UK Government had only secured enough vaccine for the total population, but they didn't. They secured more vaccine than we needed, so it was 8.28% of the relative portion of the totality of the stock as it came in.
Q. And presumably because the supply chains went up and down in terms of volume and availability and there was times when there was more supply than you could deal with and other times where you had to very carefully apportion the supplies and make sure that you never ran out on the coalface, the fact that you were given

a percentage, overall percentage, of the entire vaccine supply made no real difference operationally?
A. Yes, exactly. What we found, there was really good and close cooperation between the SROs, and that includes the SRO from BEIS on supply, so each of us would share our deployment plans and each nation sometimes was going a little bit faster or slower than the others, and there was a really pragmatic approach to ensuring we each supported each other's deployment and, as I said, I cannot recall an instance where we had to rein back our delivery because of delays in supplies, other than shocks in the supply system such as batch failures, which weren't anticipated.
Q. So that system appears to have worked.
Your relationship with the Vaccine Taskforce. The decision had been taken that the United Kingdom Government would be responsible for procurement, and that is what the Vaccine Taskforce was primarily concerned with. But was Scotland, as with all the other nations in the United Kingdom, invited, nevertheless, to be party to discussions or some of the discussions of the VTF? So some meetings that they conducted?
A. We were indeed, yes.
Q. Were you there as an observer or as formally part of the VTF Programme Board as it happened?

A. I wasn't an observer but we were briefed by BEIS but there was not a governance role in that capacity.
Q. In your statement you refer to the quirk that the VTF's governance system by which the VTF formally reports to the UK Secretary of State for Health and Social Care, had fallen behind the reality of the position which is that post-devolution, public health was a matter for Scotland, Wales and Northern Ireland, and the VTF wasn't reporting formally, or in any sense at all, to Scottish, Welsh, Northern Irish public health ministers.
A. I think that related more to the JCVI rather than to the VTF. So the JCVI has been in place for a considerable amount of time but you're right: the governance of the JCVI has not been updated to reflect a post-devolved settlement, so the JCVI formally reports to the Secretary of State for the Department of Health and Social Care, and then it is incumbent upon the Department of Health and Social Care to inform other health ministers.

It also -- if I may, it also means that the timing of when JCVI advice is announced to the public is decided by the Department of Health and Social Care, and sorry, finally that also means that the Green Book, which is often described as the bible, that the UKHSA writes which translates JCVI into the operational detail

of how it should be delivered, is not undertaken in a way that that has four-nation sign on and there were times, as I think I alluded to in my statement, where there appeared to be a misunderstanding of the way in which health is delivered in a devolved setting.
Q. You're absolutely right, of course, I confused myself because the VTF reported to the Secretary of State for BEIS and it was within BEIS that the VTF was a departmental body. The JCVI was a statutory body reporting to the Secretary of State for Health.

Did it matter, in practical terms, that there was this absence of governance reporting from the JCVI to the Minister of Health in Scotland?
A. It's difficult to say, but there were occasions where there was a suspicion that the JCVI, despite having a member and observers, didn't completely understand some of the subtle nuances in Scotland. So whether that be, for example, Scotland has a different academic year and schoolchildren go back to school in the middle of August in Scotland, and it's slightly later in other parts of the UK. It wasn't immediately clear that the JCVI understood that and therefore -- and there were some other examples, but there were times where we weren't sure the JCVI understood the complexity.

Carers may be another example that you may wish to

come on to.
Q. But in practice there were always representatives from Scotland, Wales and Northern Ireland at JCVI meetings. So you were able to say, "Well, hang on, you've gone wrong here. Actually, the academic term in Scotland starts at a different time to England and therefore the premise of what you've just decided is wrong".

You always had that opportunity?
A. Yes, in theory, although the observers and the members of the JCVI from Scotland were often clinical leads and not --
Q. Policy or --
A. Indeed. And maybe didn't have that wider, broader prospective of delivery.
Q. So perhaps the question of who attends and who observes at JCVI meetings on the part of devolved administrations is something that needs to be looked at?
A. Perhaps, as -- or indeed the governance of the JCVI to reflect a post-devolved settlement.
Q. All right. You've already said that you worked very closely with your fellow Senior Responsible Officers.
A. Yes.
Q. There already was, I think, a very high degree of openness and candour, as we'll see in a moment from some of the WhatsApps. That system, that relationship,

appears to have worked extremely well; would you agree?
A. I would indeed.
Q. And did that process allow for almost every aspect of the vaccination programme in the United Kingdom to be debated, from statistics to rollout, the issue of dosing interval, mixing vaccines, availability of stock, prioritisation, wastage, particular sectors wanting priority vaccination, workforce matters, everything?
A. Yes. Although we each, I'm sure, had a great team we were working with in our own nations, there was a bit of a kindred spirit and it was good to be able to -- at times offload but also check how others were dealing with some of the same issues.
Q. Presumably there was always going to be times when documents were produced by the United Kingdom Government and not enough time was afforded to the devolved administrations to comment on them, and also when politicians said things in the public domain which perhaps required correction subsequently, or there were unattributed comments or observations from unknown sources in Westminster which caused horses to shy and certain fluttering of feathers.
A. Yes, there were. And in particular I seem to recall in January 2021 there was a series of those tensions. And that was a time where confidence -- it was really

important that the public had confidence in the programme, and there was a risk that some of that activity would put that -- would create a lack of confidence which would -- may mean people not coming forward.

I don't think it had a material impact on the programme's ability to deploy, but it made what I think was a really difficult job even more difficult.

Q. So this is an important facet of the position: whilst at a policy and at an administrative level it was always possible for all of you to get to the right endpoint, and what needed to be done was done, it was important to maintain public confidence in the vaccination programme, that you were seen to be given enough time to agree joint positions, to agree to vaccine strategies, and so on?

A. So there was broad agreement on some of the key elements across the four nations, so, for example, when the date on which we started vaccinating a particular cohort or how we were intending to prioritise different groups. So there was broad agreement on that side.

But it was equally important for us all to understand there was subtle differences in the messaging, because we each had a different system, for example of calling people up, of inviting people, of --

you've alluded to England using primary care networks. We didn't. So there were subtle differences that we all had to ensure were carefully understood by each bit of the programme across the nations but also was embedded in our communications.

Q. And especially when they would have been talked about in the public sphere?

A. Indeed. And some of the criticisms around supply, for example, were extremely unhelpful, and at times untrue.

Q. Are you referring there to the fact that, I think at the beginning of January 2021, there was unfair and inaccurate but unattributed commentary in London concerning the speed at which the Scottish Government was delivering the vaccines which it had been apportioned under the Barnett formula?

A. It wasn't just unattributed, there was some -- I think there was some attributed comments. But -- but yes. And I think if recall correctly, the number that was being quoted in the media was the number of vaccines that were allocated to Scotland, not delivered. And it's quite difficult to provide a vaccine to someone in Wick when the vaccine is sitting in a warehouse outside Liverpool.

Q. Is that reference to a comment made in the public domain by perhaps the Secretary of State for Scotland?

A. That's correct.

Q. All right. But the position was corrected?

A. Subsequently we agreed with the UK Government that we would publish supply figures, and we did that on a routine basis.

Q. All right.

Let's look, please, at just a couple of examples friction arose but where ultimately an agreed position was reached and the problem was solved.

INQ000498602.

This concerned the review of the -- or the agreement to the UK vaccine strategy; is that correct?

A. That's correct.

Q. So in this letter, Jeane Freeman, the Minister for Health, wrote to the Secretary of State for Health and Social Care in Westminster about the process by which the draft UK vaccine strategy was to be agreed by all the nations, and essentially, she stated and complained of -- or she stated that there had been an exceptionally short timeframe provided for comment by the devolved administrations; is that right?

A. That's correct.

Q. Were you able, nevertheless, to reach an agreed position? Were you able to sign up to and comment on and no doubt amend as you saw fit, the combined UK

vaccine strategy?

A. So this may sound a bit Civil Service-y, but in the end we agreed it to not being a UK-wide strategy but an update document. I can't exactly recall what the UK Government called it, but we didn't have it as a strategy. But we did reach agreement and we did, each SRO, provide information to the Department of Health to allow them to publish a document on the date they had wanted to publish.

Q. Sir Humphrey Appleby would have been immensely proud of you, Mr Grieve. You were able to reach a position whereby you agreed the substance of the document by calling it something different?

A. In essence, yes.

Q. All right.

There were very many WhatsApps between yourself and your fellow SROs.

INQ000477804.

Let's start, please, on page 4 of this document, which is extracts from 15 December 2020. And if we go -- thank you very much -- straight to 20.55.05, so around about five to nine in the evening:

"Derek Grieve: I think this merits a deeper conversation. I'm not sure my Minister agrees it is necessarily a UK programme."

Is this in the context of a vaccine strategy?
A. I think this was in relation to an earlier message from --
Q. Right --
A. -- it may have been Emily, where she references the Prime Minister and the Secretary of State believing this was a UK-wide programme, and I was correcting that.
Q. All right.
And presumably there were multiple occasions on which you had to debate the merits of documents produced at the UK Government level, you had to debate whether or not they were accurate, whether they properly reflected the position in each of the devolved administrations, and, of course, whether they were right. And that was part and parcel of the process by which, in a devolved nation, you have to agree something that has got a very high level of UK Government input?
A. There was agreement that all four bits of the UK had to work together and respect each other's different approach. But as I said, particularly in January and the December, the thing on all of our mind was the public -- the importance of the public having confidence in the programme. And if we had put out information which was clearly wrong or inaccurate, that could have dented confidence.

Q. Page 11. On 4 January 2021, there is some communication concerning communications and the issue of communications.
So page 11. Thank you very much.
4 January at 20.49, Gillian Richardson, on behalf of Wales says:
"No one is handling Comms to 3 non English nations. Ministers furious."
What do you understand that to be a reference to? Was there an issue with the way in which, as you say, on a communication level and a public level, communications being made on behalf of all the nations were correct?
A. Yeah, I seem to recall, and I think there's an earlier message in this chain where I asked Emily, at 19.58, if the PM was about to announce the timeline for completion, and I recall the Prime Minister did make an announcement at 8 o'clock that evening about England's timeline for completing priority groups 1 to 4. We didn't know that announcement was going to -- or I didn't know that announcement was going to happen, and I don't think any of the other SROs did and as soon as that announcement was made, understandably, all parts of our respective systems were asking us: "Can you match that timeline?"
And we had predicated our deployment plans on the

information we had about incoming supply, and again, we hadn't -- we hadn't had those discussions about understanding if that assumption was right because our deployment was based on using the maximum amount of supply, and our suspicion was that colleagues in England knew they had more supply than we had, and as I say, I didn't know that (inaudible).
Q. So it was a technical issue ultimately but one that was being resolved?
A. Yes.
Q. Were you occasionally bedeviled in your work by false or inaccurate accusations, as you saw it, being made in the press and the public domain about the state of vaccination in Scotland and, indeed, your colleagues respectively in their own nations?
A. I think I, and I suspect others, dealt with it as the flotsam and jetsam of working in the programme but it meant that when there was misrepresentation out in the public domain, we had to work doubly harder to ensure the correct information was out there, and as I've said, underpinning that was ensuring the public had confidence in the programme itself.
Q. If we could look at page 16 at 11 am approximately, one of you refers to the undesirability or the depressing nature of politics of accusation.

So page 16 -- thank you very much -- at 11 am and 41 seconds:
"Derek Grieve [it was you]. The politics of accusations relating to delivery being out of sync with supply in Scotland is proving to be challenging."
Was that a glorious piece of understatement?
A. So I think this relates to what you were asking about earlier where some of those unattributed and, later, attributed sources were talking about supply figures being in the public domain.
Q. Was there a particular problem in relation to the inability of the devolved administrations to put data into the public domain at least until late January, and therefore being unable to bat off some of the unfair accusations that were being made concerning practical delivery and rollout?
A. That's exactly right.
Q. So if we look at a letter, please, INQ00498603.
Jeane Freeman had occasion to write to Matt Hancock on 31 January and she copied in Vaughan Gething in Wales and Robin Swann in Northern Ireland. And she says this in the second paragraph:
"In recent weeks, devolved administrations have been put in the untenable position of being unable to share this data at the request of the Vaccine Taskforce -- but

at the same time, see these figures [being] briefed to the media, and apparently, to elected representatives of the Conservative Party."

Well, there's a little political dig in there, but putting that aside, was this issue, from the position of the devolved administrations, of them being unable to put data into the public domain resolved? Did they continue to be unable to put it into the public domain or did you put into place a system whereby weekly or monthly you could put the figures up?

A. Yeah. So it was resolved and we did put supply information up on the Scottish Government Covid website. I think, just to say, the programme and Scottish ministers were really keen that we provided as much information to the public, Parliament, and the press. So we published a series of deployment plans to help explain to the public and others what the programme was doing and while it was doing it, particularly -- and that was particularly important because we were asking quite a lot of people to wait their turn, and we needed the public to understand why we were taking the approach we were taking, and having some of these figures that we weren't able to rebut was putting that at risk.

Q. Now, Mr Grieve, we can look, I think, at some of the more specific, practical aspects of the vaccination

programme in Scotland starting with, please, the Covid-19 vaccine deployment plan. Did you bring together or produce an overarching plan for the delivery of vaccines in Scotland?

A. So as I alluded to, there was a series of plans, I think the first was published on 13 of January 2021.

Q. And presumably you'd started working on these plans months before?

A. We had. But of course we didn't receive the detailed advice from JCVI and MHRA until the beginning -- well, the beginning and through December.

Q. Well, you didn't know that any vaccine would be authorised until, for sure until the beginning of December?

A. That's correct.

Q. And you therefore didn't know, for sure, what the practical consequences would be of having vaccines that had to be delivered at minus 70 degrees centigrade?

A. Exactly right.

Q. All right.

Could we look, please, briefly at the vaccine deployment plan. I can't tell you, I'm afraid, which emanation this -- oh, it's the 14 January one, so it's the first plan.

Page 3, the third paragraph, we can see there that

you envisage -- and indeed this is what happened -- that:

"Vaccination will take place in care homes ... GP surgeries, local vaccination clinics, community pharmacies, mobile vaccination units and mass vaccination centres."

Page 6, unlike, I think, the overarching plan in England when you set out the cohorts of persons who would receive vaccination in the priority list, you were able to, and you did, estimate the numbers of people who were expected to be vaccinated in that cohort. And we can see there all the JCVI groups, 3.375 million.

A. That's correct.

Q. And did those figures over time prove to be broadly correct?

A. They were. They were -- this, I suppose, is an illustration of the modelling we used to help us understand when we'd achieved maximum uptake against each cohort. It's probably fair to say, though, that cohort 6 was more complicated than we first anticipated but generally speaking, these numbers broadly aligned with our expectations.

Q. We'll look at it in a moment but cohort 6 had within it, did it not, the reference to those at a higher risk of serious disease and mortality and unpaid carers, and

that gave rise to terminological/definitional issues as to who might be regarded as being at higher risk and who might consider themselves an unpaid carer?

A. That's correct.

Q. All right. Who was responsible for the training and deployment of vaccinators?

A. So that was -- each territorial health board had that responsibility, but they were helped enormously by colleagues in NHS national -- Education -- Scotland, who developed a suite of products and training tools to -- that local that the territorial boards could use.

Q. And we've heard evidence from Dame Emily Lawson to the effect that there was a protocol drawn up in London in relation to the training of vaccinators in England. Was a similar process adopted in Scotland by which a highly prescriptive list of directions was drawn up for use in training?

A. Yes, so every time there was a JCVI -- different JCVI advice or, indeed, advice from the MHRA, then we often updated the protocol and issued that as part of the package to develop and train both existing vaccinators but also new vaccinators joining the workforce.

Q. You've referred already to the issue in cohort 6 of unpaid carers. Can we look, please, at a submission that was prepared for the Cabinet Secretary for Health

and Sport.

INQ000376371.

Did this come from you, Mr Grieve? Do you recall?

A. It didn't come from me. I think it came from the unpaid carers policy team.

Q. All right. Within your division or within the Health Protection Division?

A. It came from another bit of the Health family, but I would have seen and I would have been part of the sign-off of this advice before it went up.

Q. All right. Paragraph 6 states that:

"Official statistics indicate that around 690,000 unpaid carers in Scotland ... [although that may be] likely an underestimate."

So there was a significant problem -- or at least the terminological debate or definitional debate about who was an unpaid carer had the potential to be of enormous impact, given the sheer size of the cohort.

A. Yes, but it's important to say that there was a piece of legislation in Scotland, the Carers (Scotland) Act, which set out the definition of a carer in Scotland, which I don't think was the same elsewhere in the UK.

Q. Indeed. And if we go over the page to page 2, paragraph 10, the problem lay therefore not in the absence of that statutory structure, but that there was

no single register of unpaid carers and local data was patchy.

A. That's correct.

Q. All right. And presumably, there's a difficulty with people attempting to self-identify, because, whilst that might be absolutely fine in practice, it doesn't allow the government to be able to understand in advance how many people are likely to self-identify?

A. Yes. So there were some unpaid carers who were in receipt of benefits, and we used that data to identify and target them for invitation. But you're right, for those that were not in receipt of disability benefit or benefits, then there was no way for us to immediately identify them and therefore we moved to a self-identification model.

We did put in a couple of controls, though. So we used -- in the national -- in the vaccine helpline we adapted the script that when somebody phoned up and self-declared, to seek assurance that they were actually an unpaid carer. And likewise, if somebody was booking an appointment on the system, we asked them a series of questions to try to filter out -- we -- of course there was always a risk that somebody may be playing the system. Generally speaking, though, we -- the level of unpaid carers we administered was broadly in line with

our expectations.

Q. Do you assess that the system you put into place did allow effective offering of vaccinations to unpaid carers in the way that you had obviously wished?

A. Yes, I do.

Q. Scotland has a number of rural communities, that's obvious and self-evident. How did you alter the system of delivery on the ground to ensure that those rural and particularly Highland and island communities were properly served?

A. So, as I alluded to, we devolved responsibility to each health board, but we gave the -- the central team gave each health board quite a lot of support. So when Highlands, for example, and the islands, were developing their deployment plans and explaining to the programme where they were having vaccination clinics, how they were supporting people to get to vaccination, these were scrutinised and sometimes challenged, and changed. But we also, particularly in the Highlands, used far greater role of outreach activity. So vaccination teams going to rural and remote areas. And to that end, we did something called bundling, which might sound a bit technical but in essence we gave authority for the health board to not stick rigidly to the prioritisation group when it made operational sense to go to

a community and just vaccinate, for example, a whole village or an area, because that reduced the risk of vaccine wastage.

Q. Was the health board or health boards responsible for, in particular, the Highlands and islands, able to roll out that more particularised, more tailored form of the delivery from the start of the vaccination programme or did it not really get going until later?

A. So the role of bundling and outreach was -- tended to be deployed as we came down the cohorts a little bit, but -- bearing in mind the very start of the programme was directed at care homes and health and social care workers. It would be unfair for me to say we got that bit perfectly right. There was challenges. There was absolutely challenges with all of that. And as well as rurality, of course, there was inclement weather, and we were vaccinating over winter, early 2021, and that had an impact on people's ability to travel to vaccinations. And that's not just people receiving the vaccine but also the workforce.

Q. Would it be fair to say that in relation to some of the younger age groups, age cohorts, for example, the over-seventies and the over-sixties, and in relation to the clinically extremely vulnerable or, you would say, high clinical risk, in the Highlands and islands, offers

of vaccination and delivery of vaccinations didn't proceed at the same pace as they did in the more urban areas?

A. So it's a more difficult job in rural areas, by the very definition, because -- but there was the same level of support of outreach.

I should also mention each health board used third sector organisations to both pick up the individuals at home and take them to and back for the vaccination. But of course, within rural areas, that's a more difficult job, and you can -- by its very nature, in an urban area you can support more people to get to clinics than you can do in a rural area.

Q. Did there come a time in May 2021 where you recommended the approval of funding for the Scottish Ambulance Service to assist in the rollout, particularly for more rural areas, so they could get out to particular houses, to the housebound --

A. Yeah.

Q. -- and also to those who were unable to travel or who feared the risk of infection by travelling to vaccination sites?

A. Yeah, we did indeed.

Q. How big a contribution did that Scottish Ambulance Service facility make?

A. That was hugely beneficial. And as you alluded to at the beginning of the programme, it helped us to target the most vulnerable, but as we came down the age cohorts it also allowed us to deploy outside football matches and shopping centres and areas where the younger population are more likely to go, and take the vaccine to them rather than ask them to come to the vaccine.

Q. In relation to the vaccination of 12 to 15-year-olds, the Inquiry is aware that, in England, vaccination of children was generally, although perhaps not exclusively, but to a very large extent, carried out by SAIS, the school immunisation service.

A. Mm.

Q. In Scotland you did it differently, did you not?

A. We did.

Q. And how did differ in general terms?

A. So it's fair to say that, up until that point, we had delivered, for example, the child flu vaccine through schools. We had done that. But the programme took the view that if we had done that with the Covid vaccine there wouldn't be the opportunity for parents and guardians to have that informed consent discussions if they had any concerns about the safety of the vaccine, given the advice from JCVI was nuanced and more balanced. So we felt it was important to offer

a community-based approach.

And I think as I also said in my statement, it also allowed us to develop, for example, child-friendly vaccination clinics based on conversations we'd had with the Gold Coast in Australia, who were already vaccinating children.

It was a bit of a risk, I'll be fair. We didn't know if it was going to work. But to be fair to the programme and indeed to ministers, they agreed to take that risk, and I think in the end it demonstrated that we had quite high and good uptake of vaccination for children.

Q. You had a higher uptake of vaccines amongst 12 to 15-year-olds in Scotland than, I think, was achieved in England; is that right?

A. Initially. I think everybody broadly caught up with each other but certainly there was a point where Scotland was slightly ahead of the league table.

Q. And what do you mean by the -- in the context of vaccination of 12 to 15-year-olds, "community-based approach"? A community-based approach, what does that mean in practice? Does that mean mobile units, community hubs, or attending local vaccination sites under the health board?

A. It's the latter. It's a local, often a local

vaccination site, which was often adapted to make it more child friendly, so there was space to have those conversations with parents and guardians, and decor and the like, for -- that would make it more welcoming for children rather than being a harsh clinical environment.

Q. And may we please have a shout out for the military, Mr Grieve. Did, as in England, the military provide a great deal of help by way of logistical support, planning, the availability of -- making available vaccinators, and setting up vaccination centres and transport facilities in Scotland?

A. Yeah, likewise in Scotland, the military played a hugely important role, and the ability to flex and for the programme to pivot and expand, not least to respond to Omicron, but equally, we turned the, what was the Scottish Exhibition and Conference Centre which was our version of a Nightingale Hospital, into a mass vaccination centre. The military led that work and delivered it at breakneck pace. So the military were hugely supportive and I'm immensely grateful for all they did.

Q. Did they act as vaccinators as part of their functions in local vaccination sites?

A. They did. They did indeed.

Q. In England we've heard evidence that there were

NHS-trained vaccinators used, obviously GPs, pharmacies and dentists, and also that there were -- well, there was -- a very large number of volunteers stepped forward in response to an invitation, who were then trained to assist?

A. Yeah.

Q. There were also volunteers who volunteered themselves to act as stewards in community vaccination sites.

A. Yeah.

Q. You took a rather different approach in Scotland to the vaccination workforce and whether -- the degree to which you could utilise volunteers, didn't you?

A. So we used healthcare support workers perhaps more than other parts of the UK, hence the protocol became incredibly important. So they were overseen by vaccinators. So -- but we did use volunteers. We put numerous calls out, and used -- each health board had a bank of staff we could call on and we could train and deploy, but you're exactly right: we also sought support from third-sector organisations who did a whole raft of activity, everything from meeting and greeting at the front door, helping to marshal car parks, to, as I've alluded to, physically transporting people who couldn't get to or from the vaccination centre, as part of the programme.

Q. So to be clear about this, although you used volunteers who volunteered themselves to help carry out vaccination, to be the vaccinators, they were trained up and formally -- perhaps it's a matter of definition only -- became healthcare support workers?

A. So there was a mix of both. But yes, we used volunteers, and they were trained and qualified prior to deployment.

Q. Turning now to the topic of how the Scottish Government addressed inequalities. May we take it -- and certainly the evidence before the Inquiry suggests this -- that it was obvious there was going to be a problem with or an issue concerning the degree of take-up in certain marginalised and ethnic minority communities.

A. So we knew from other immunisation programmes that uptake wasn't universal for all groups.

Q. Did you put into place certain bodies and structures to focus specifically on addressing barriers to access and trying to increase confidence and reduce inequality of outcome, so there was a vaccine equalities and inclusion team set up, and a National Vaccine Inclusion Steering Group, and directives given to the health boards requiring them to formulate, to use the nomenclature, delivery plans for addressing these issues?

A. Yes. If I may --

Q. Please.

A. -- before we started the vaccination programme we tabled a Cabinet paper and that Cabinet paper set out the policy position for what would become the Covid programme. And as well as determining which ministers agreed to follow JCVI advice, that policy position sought to recognise that the programme had taken a human rights-based approach, and therefore, that guided our thinking on how the vaccine would be deployed and all of the things you've alluded to about addressing inequalities was central to that.

Q. Could we have, please, INQ000240531. This is a document dated 8 March 2021. It sets out actions to the health boards for, to use the words of the document, "inclusive vaccination planning and delivery."

Just by way of example, we can see on this page:

"Aim: increase vaccine uptake in all community groups".

Area: communication.

Drivers of inclusivity.

And then importantly: "Health Board Actions": Provide marketing material, consider alternative communications, consider particularly use of social media and radio in a targeted way, local communication campaigns, sharing best practice.

Then if we go down the page, to page 2, please, down the document to page 2, we can see the various limbs of, to use again the nomenclature, delivery plans.

So accessibility of transport and clinics, engagement, staff training, data and evidence.

A. Yes.

Q. This is all self-evidently very laudable. It's quite high level, I mean, a direction to a health board to use clear and simple messaging to make sure vaccination centres are properly accessible. Did you leave it to a large extent to the health boards to decide for themselves how, in reality, these aims would be put into practice?

A. In short, no. So as well as the boards -- each health board requiring to develop their plans, taking account of this, the team within government was reaching out to individual boards and supporting them. But we were also using some of the uptake data that we were getting, and if we were seeing evidence that uptake was lower than we were expecting, we would be directly engaging with that health board to understand what they were doing, what more they needed to do, and finally, I should also say, the team within government that was leading on this work was also engaging with a whole range of groups and bodies that would be helping us understand was what we

were doing working? And if not, what more could we do?
Q. So let's just break that down a bit.
So the Covid-19 Vaccines Policy Division, of which you were head, or some other division in the Scottish Government, would be on the phones getting in touch with local providers, local groups, local community champions, trusted figures, charitable organisations, and making arrangements for proper engagement, proper communication to communities, as well as physically getting patients to sites.
So it was being driven from the centre. You were involved in the minutiae of the practical arrangements and not just leaving it to the health boards to work it out for themselves?
A. Yes, and on this and on many other things, as I alluded to, the mantra of the programme was: national led and locally delivered.
Q. And do you think that division of responsibility worked in outcome?
A. I think it did. Uptake in all groups wasn't as high as any of us would have liked, and in many ways we were trying to build trust and credibility at a time -- and that takes time -- it does take time to build that trust and credibility, with some of these communities that had a deep mistrust of the state or with the health system.

Q. Do you assess in hindsight that enough was done both at the Scottish Government level and at health board level to ensure that barriers in the way of particular groups and marginalised groups, migrants, members of the Gypsy, Roma, Traveller community, that barriers were brought down or sidestepped, and that enough was done to encourage people to take up the offers of vaccination?
A. I suspect we could always do more. I think we did as -- I reflect we did quite a lot but we could probably have done more.
Yeah, so I know in the engagement I talked about with the teams and some of these groups, we -- there was really candid and honest discussions about how effective our interventions and support was, and -- and as a result we changed and pivoted our approach quite often, but we also engaged in different forums and -- that we hadn't traditionally engaged with. And as you alluded to, we used quite a lot of trusted community and respected voices, as well as using different centres, be it mosques or black African churches or whatever it is, we sought to respond to the feedback we were getting from the communities themselves.
Q. And finally, in relation to disabled people, you've already referred to the fact that initially, I think, there wasn't a Learning Disability Register in place in

Scotland; is that right?
A. That's correct.
Q. Did you put one into place?
A. I don't believe there is one. I think the JCVI advised that we should be -- we should use it, and Scotland didn't have one. I don't -- I'm not sure if it still does, but we don't have such a thing.
Q. So how did you resolve the problem of whether you were properly identifying and making sure offers went to persons who were disabled?
A. So we took a liberal definition of "learning disability" and used that as the basis to call individuals forward.
Q. Because learning disability was a particular identified group in the cohorts of priority?
A. Exactly.
Q. And did you issue guidance to health boards to assist them in identifying who you believed should fall within cohort 6?
A. There was guidance issued. It wasn't issued so much to health boards themselves, but it was through the system that called up people for vaccination, or as part of the screening tool when people were either phoning to book an appointment or trying to book an appointment online.
Q. Mr Grieve, in your statement at page 34 -- we needn't go to it -- you've kindly and thoughtfully set out a number

of areas in which you believe that the Scottish Government innovated in a way that perhaps differed from the rest of the United Kingdom, and I just want to focus on three of the seven or eight which you mention, which appear to us to be quite different from the way things were done elsewhere in the United Kingdom.
The recording of ethnicity in the data system at the point of vaccination was hugely significant, was it not, and you've already said that it had a great impact.
You ran, secondly, a vaccine helpline.
A. Yeah.
Q. Was that of great assistance?
A. It was, because although we had a digital platform to allow people to book, not everybody had access to a digital platform. And, equally, even those that did have access sometimes wanted to speak to somebody. So having somebody at the end of a phone to ask some questions was really helpful.
Q. And lastly, you refer to the use of blue envelopes.
A. Yeah.
Q. What was that?
A. Yeah, so I can't take any credit for this. But it was a huge innovation. So at the very start of the programme we had evidence that, particularly for older cohorts, getting an appointment was important. And when

we were considering how -- what -- how that might land on -- literally through letterboxes, I seem to recall the Cabinet Secretary, Ms Freeman, who was, I think, the Social Security minister beforehand, reminding us that not all white or brown envelopes that come through give you good news. So we moved to have a blue envelope.

So as well as helping the Royal Mail at the sorting office prioritise these letters, which they did, it also meant that when that blue envelope landed through the door, it was almost a version of push marketing. It was a prompt, a call to action, to come forward. And I think as I said in my statement, I seem to recall on social media there was loads of videos of people joyous at receiving their blue envelope. So that was a real innovation.

LADY HALLETT: Some of the best ideas are very often the simplest. Brilliant idea.

MR KEITH: My Lady, that concludes --

LADY HALLETT: That completes your questions, Mr Keith?

MR KEITH: -- my questions.

LADY HALLETT: Ms Mitchell will have some questions for you.

Questions from DR MITCHELL KC

DR MITCHELL: Mr Grieve, I'm instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved. Earlier today you stated in your evidence:

"Because supply was so constrained, the programme ... had a laser-like focus on ensuring we didn't waste vaccine wherever possible, so ... that drove us to a model which protected as much as possible all vaccine supplies that we received."

It's the experience of members of the Scottish Covid Bereaved that some health boards did try to use all the vaccines but some threw them out at the end of the day so that vaccines which could have been used were not. Were you aware that this was being done?

A. So we did receive feedback from every vaccine centre. There was a daily stand-up at 8 o'clock every morning and sometimes at the end of the day we were getting feedback from vaccination areas. There were some practical issues about when a vaccine expired. Once it had been defrosted it was only allowed to be used for so long, and once it's diluted it can only be kept for so long and then it has to be discarded.

We did assume, however, a vaccine wastage of about 5% at the start, because of all of the complexities with the vaccine, and I seem to recall in March 2021 we were recording wastage at 1.8%, so far less than we were expecting to receive.

Q. But did you know that some health boards were throwing them out at the end of the day? There's at least

anecdotal evidence that some were throwing them out at the end of the day, some were phoning up, for example, relatives that hadn't had jabs and saying, "Please come in and we can give you the jab" there and then?

A. So I know some centres were having to discard them because of the expiry I've mentioned, but I also know that some centres were opening the offer up to others, and whilst it was relatively small numbers, the challenge we had about deviating completely from the prioritisation list was it was sending out mixed messages to the public who, as I alluded to before, many of whom we were asking to wait their turn to ensure we vaccinated the most clinically vulnerable first.

Q. So what you're saying was there was a balance between making sure that all the vaccines were used and making sure the wrong message wasn't being sent by some people hearing that other folk had got the vaccine first?

A. Exactly.

Q. On that particular issue of mixed messages, my next question is this: it's the experience of the Scottish Covid Bereaved that different health boards delivered the vaccination programmes in different ways. You've explained to us earlier in your evidence, deployments, as you have described it. This has led, at least in the Scottish Covid Bereaved group, to some confusion between

family and friends who lived in different health board catchment areas. What, if any, consideration was given to alerting and educating people to these differences in approach so that confusion wouldn't arise?

A. So there was small and subtle differences between health boards but, generally speaking, all health boards used the same system for calling people up, for the ability to go online and book an appointment, or phone the helpline and book an appointment. Where the vaccine was delivered would vary, clearly, from health board to health board. But it's probably important to note that the vaccine booking system allowed individuals to book an appointment outwith the geographical health board. And that was particularly important as we came down the age cohorts because somebody who, I don't know, lives in Fife but works in Edinburgh could get their vaccination in Edinburgh, for example rather than have to travel back to Fife where they live.

Q. I understand that there were differences and sometimes those differences were subtle but my question was, was there any consideration given to alerting the public to those differences so that they were aware that if their cousin in the Highlands and Islands said that they were getting their vaccine one way, that they would know, that's okay, we're doing it differently in our health

board?
A. Well, each health board had its own, and we supported them, their own local comms to their community, absolutely, but I suppose the point I'm making is the differences weren't that major, so health boards didn't, for example, we didn't have one health board vaccinating priority group 4 whilst another health board was vaccinating priority group 6. That didn't happen. All health boards moved in lockstep with the approach -- so there was core fundamentals which were agreed across all health boards to avoid that very point you're making to me.
Q. Moving on, it's further the experience of the Scottish Covid Bereaved that vulnerable people within care home settings were being invited to attend mass vaccination centres. Firstly, I suppose, were you aware of that?
A. So do you mean residents or staff?
Q. Residents.
A. I'm not aware of residents being invited from a care home to a vaccination centre. I can't recall of an example of being made aware of that.
Q. Okay.
I then will simply move to the next question, which was: what happened, if any, consideration was given to ensuring that vulnerable people were not reliant on

attending mass vaccination centres? You referred in your evidence earlier, for example, to the inclement Scottish weather at winter. Was consideration given to those sorts of things for vulnerable people attending centres?
A. Yes, there were. And equally, as well as part of the deployment going through the cohorts, there was often a period at the tail end of that cohort of mop-up -- what we described as mop-up activity. So if, for example, there was lower levels of uptake in the clinically vulnerable, for example, in an area, we would be exploring with the health board to see how much more we could do, and that might include, for example, more outreach activity.
Q. More, sorry?
A. Outreach activity.
Q. By that, meaning asking people to come in from other --
A. No.
Q. -- areas, or from other --
A. No, by that I mean vaccination teams going out to people rather than people coming into the vaccine centre.
DR MITCHELL: I see.
My Lady, I'm obliged. Those are my questions.
LADY HALLETT: Thank you very much, Ms Mitchell.
Like your colleagues, the other SROs, you obviously

had an extraordinarily difficult task, Mr Grieve, and obviously performed it beautifully for the people of Scotland. So thank you very much for what you did during the pandemic and thank you for your help with the Inquiry.
THE WITNESS: Thank you very much, my Lady.
(The witness withdrew)
LADY HALLETT: Thank you. Very well, I shall return at 11.40.
(11.26 am)
(A short break)
(11.40 am)
LADY HALLETT: Ms Stephenson.
MS STEPHENSON: My Lady, the next witness is Professor Dr Gillian Richardson.
Please can the witness be sworn.
PROFESSOR DR GILLIAN RICHARDSON (affirmed)
Questions from COUNSEL TO THE INQUIRY
LADY HALLETT: Hope we haven't kept you waiting.
THE WITNESS: No, that's all right.
MS STEPHENSON: Please can you say your full name.
A. I'm Gillian Richardson.
Q. Thank you for attending to assist the Inquiry.
Just some preliminary matters. You made a witness statement dated 16 August 2024, INQ000501330. It runs

to 66 pages and 105 exhibits. It contains your signature and a statement of truth. Can you confirm that you have read that statement recently and its contents are true?
A. I can.
Q. Thank you.
Before we get on to your professional background I know you wish to say a few words about the efforts made by your team.
A. Thanks so much.
I'd just like to thank my colleagues, really, in NHS Wales and Welsh Government, including all the health board Senior Responsible Owners, the directors of public health, GPs and primary care contractors, Public Health Wales, especially the Vaccine Preventable Diseases programme and the Vaccine Surveillance Team, Wales Blood and Transport Shared Services and the vaccine workforce, who helped us to deliver the rollout of the vaccine including third-sector colleagues, volunteers, and military colleagues.
Q. On to your professional background. You have a medical background. You initially worked as a GP, is that right, before progressing through the public health and research route to become a consultant in public health medicine in the early 2000s?

A. That's correct.
Q. And you've held the positions of Director and NHS Executive Director of Public Health of, in fact, two health boards in Wales, and in 2017 became Deputy Director of Policy, Research and International Health in Public Health Wales; is that right?
A. That's right.
Q. Of most relevance to your evidence today, in late 2019, you joined Welsh Government on an informal basis and was that to cover, in the absence of a senior civil servant in the Office of the Chief Medical Officer?
A. That's correct, yes.
Q. Effectively on loan from Public Health Wales?
A. Indeed, yeah.
Q. Your work, of course, intensified as the Covid pandemic hit and you were at that time acting as a professional adviser to the CMO, formally seconded, and eventually stepping into the role of CMO Covid-19 response team lead on Covid-19 vaccines in Wales; is that right?
A. It is.
Q. In early June 2020 it was agreed that a Covid-19 vaccination programme board would be established in Wales which you would chair. Please can you explain what the purpose of that board was.
A. The purpose of the board was to plan for the development

of a rollout of a vaccine. There were several candidate vaccines, so we had to prepare for any of those to be the one that would come first. We had to look at delivery models for planning the rollout to the sectors of the community that we had some prior notice but hadn't quite been decided yet, but we knew that it was going to the elderly population, it was going to be particularly care home residents, health and social care workers, and that it was likely to be an age-based prioritisation rollout. So we were able to do tabletop exercises with all the health boards where we all had joint learning and basically did some tabletop planning.
Q. You became the Senior Responsible Owner for the Covid-19 vaccination programme, a position that you held until 2021. You point out that no formal appointment was made for that role. How was it that your appointment came about?
A. I think because I was the CMO lead for vaccines and at that time it was quite a small team in Welsh Government. We had, obviously, huge amount of efforts going on in the Test, Trace and Protect functions as well as emergency response, and I happened to have the most experience with vaccination in the team, having worked abroad on mass vaccination campaigns in Africa.
Q. And in April 2021, your role shifted to Deputy Chief

Medical Officer, and Claire Rowlands became the Senior Responsible Owner.
A. That's right.
Q. However, did you continue to maintain your existing relationships with the SROs in the other of the four nations to attend meetings with them and to have a great deal of input into the programme?
A. Yes, indeed. And to be the public communication CMO, sort of, representative, yes.
Q. You describe in your statement you formed a small core team in Welsh Government to coordinate vaccine planning and infrastructure in the way you've described. You also describe staffing difficulties within the Office of the Chief Medical Officer for Wales. You were, as you've explained, stepping into a role that had previously not been occupied. And the pressures on public health services during the pandemic no doubt exacerbated those issues.

Did the staff shortages that you refer to in detail in your statement prevent, in your view, the vaccination programme planning running properly, or efficiently in Wales?
A. No. I wouldn't say it did, because we had excellent support from Public Health Wales' Vaccine Preventable Diseases unit, Dr Richard Roberts then in charge and his

team, and also we had tremendous support from the delivery unit of the NHS with Jeremy Griffiths stepping into the Chief Operating Officer role.
Q. The Wales Covid-19 Vaccination Board, which you chaired, had a number of aims. I'm not going to reel through all of them, but were core aims to develop a delivery plan, to manage and monitor vaccine uptake and equity of access, and to ensure that stakeholders and partners were informed on the progress of the development of the plan?
A. Indeed, yes.
Q. Did you have a mission statement and if so, what was that mission statement?
A. We did. Our mission statement was that we were to immunise as many as possible, as swiftly as possible, safely, with minimum vaccine waste.
Q. And there were certain UK-led workstreams, as they're referred to in your statement, such as vaccine safety and approval, prioritisation. That was being led primarily by MHRA and JCVI, and is it right that that work wasn't duplicated by your team, that the emphasis of the vaccination board's workstreams was delivery?
A. It was. Although we did have a kind of sub-prioritisation. We had our own Vaccine Clinical and Prioritisation Group, so that if the JCVI guidance

needed further interpretation to operationalise it, that that group could be consulted.

And we also sometimes made our own decisions on vaccine safety. So, for instance, we did not suspend the 15-minute waiting interval for clients with -- below 16 and with learning disabilities or those in whom there may not be capacity to understand an anaphylactic reaction.

Q. We'll come back to the clinical advisory group and some of their advice later on, but in terms of the safety decisions, other than the decision that you have just explained, were there any other safety decisions that were taken differently or did you otherwise follow --

A. No, sometimes I would write to the chair of JCVI seeking more urgent clarification on matters such as the age threshold for the safety of the AstraZeneca vaccine, because our programme was about two weeks ahead of the other nations at one stage, and it was at a crucial stage: when AstraZeneca discussions were in train about the age range that was most appropriate for that vaccine.

Q. And that was to seek clarification?

A. Absolutely, yeah.

Q. The vaccination board had number of subgroups, didn't it? We needn't go into all of their work but there were

subgroups for things like workforce, logistics, data and surveillance, primary care, care homes.

A. Mm-hm.

Q. In total, seven subgroups dealing with those specialist areas. Was that structure of those specialist matters being delegated out to subgroups? Was it effective?

A. Yes.

Q. Was it over-complicated or did it work?

A. It worked really well because each subgroup had representation from key stakeholders, and also from the deployment arm from health boards.

We also had a stakeholder forum which was basically, initially, part of the board. So right up from June 2020, we did have third sector and patient group representatives helping us in the planning and design of our programme.

Q. The functions, finally, on the workings of the Wales Covid-19 Vaccination Board, the functions of the board were divided in June 2021 -- or perhaps a better word to use is transferred -- to the Wales Covid-19 Vaccine Delivery Programme Board.

A. Yes.

Q. Can you just explain just in summary why that change happened in June 2021?

A. Yes. I had been working with the Auditor General for

Wales, and the Audit Commission had produced a report and, whilst it was complimentary, there were obviously areas that we needed to look ahead to for the future. And in terms of mainstreaming a programme, there are phases when perhaps it is best to do that.

So, following the delivery of the primary courses in Wales, I requested a gateway review on the programme, and the gateway review recommended some actions which we took, and I became a clinical lead.

My senior civil servant colleague Claire Rowlands became the SRO, and we had our Chief Pharmaceutical Officer, Andrew Evans, and Jeremy Griffiths, the COO, acting as very much a gang of four at the centre of the co-ordination aspects.

Q. Local health boards. The National Health Service in Wales collectively refers to the seven local health boards as well as trusts and special health authorities. In terms of the role of the health boards, what was the ethos of the approach in terms of the independence or responsibility that was delegated to them?

A. Yes. They'd been involved with us in the conception of the response, obviously. It was a distributed leadership model. It used the existing governance mechanisms which were there. So our Healthcare Inspectorate Wales has responsibilities to inspect our

health boards and their services. They have responsibilities to report through to the Director General in Welsh Government, who is also the chief executive of NHS Wales. So we used the existing structures but in a distributed leadership model where we set up the parameters for performance, for instance, or for the aspects they needed to consider, such as equity, and then we would monitor and they would assist us to monitor their performance, and also to share, you know, reasons perhaps for exceptional performance in one area of Wales so that it could be a subject of learning for the others.

Q. So, using that example of equity, you set the parameters for what they ought to be achieving, but the health boards have discretion and flexibility to decide what programmes they will initiate to achieve that? Is that a fair example?

A. Yes, that's correct. Although we didn't leave them, you know, sort of unsupported. We had a central Vaccine Equity Committee which arose from the stakeholder forum in due course, and we also had a vaccine equity action plan, which we asked them to report on at each of the monthly meetings.

Q. Did that flexibility extend to the health boards in the way you've described? Did it cause any difficulties

with a lack of parity across Wales, with different people having different experiences of rollout?

A. It sometimes led to misunderstandings, it's true, but the pace of the vaccination programme was so intense that usually any disparities were extremely short-term, because all of the health boards achieved -- our priority groups 1 to 4 were all vaccinated and the offer had been extended by mid-February.

So, in line with our first vaccination strategy.

Q. We've touched on the advice that JCVI, but in your view, was there significant or sufficient, rather, Welsh participation or engagement with the JCVI in its decision making?

A. We had excellent -- an excellent observer, Anne McGowan from Public Health Wales who went to every JCVI meeting, and had done for the years previously to the pandemic. We also had a Welsh Government observer that we were able to put in place. What we didn't have, which I think was important, was that we didn't have a voting member. So we had observer status. So in that respect as a devolved nation, we did have -- I had to perhaps sometimes highlight things to the chair that I considered issues that we needed to have addressed.

Q. And would you consider that would be an area that might be improved upon?

A. Yes, I do believe that each of the devolved nations needs a voting member and I do believe that in the scientific subgroups that look at the research evidence in particular, and also particularly perhaps for the MHRA, if I may say so, that it would provide strength and also help understanding back at base if the devolved nations had representatives.

Q. Wales had its own Vaccine Clinical and Prioritisation Group as well as its own Moral and Ethical Advisory Group.

A. Yes.

Q. Did both of those groups offer advice on the advice that had come the JCVI, how to interpret it, and how it might operate in Wales?

A. Yes, indeed, and our Senior Medical Officer, Dr Heather Payne sat on both and chaired both.

Q. I want to move on, then, to the issue of the allocation of vaccines to Wales, and the Inquiry has heard that the Barnett formula was the basis for allocation; in simple terms, the total number of vaccines provided to Wales was a share of --

A. Yes.

Q. -- UK vaccinations according to population size. You expressed some concerns about the use of that formula in your statement. Could you explain what those are,

please?

A. Yes, in brief, the Barnett formula is based on a whole population estimate and what proportion of that each country should be allocated. But if you have a vaccination programme that is targeting specific age bands in the population, the age bands are different between the two countries. So, for instance, if we were required to immunise groups 1 to 4, then our share of, say, the over sixties, in Wales, by 10-year age bands, was 26% of our population, whereas for the combined England and Wales population it was 22.7. So, in fact, we recognised that there was a gap.

Also, our all-cause disability adjusted life years calculation in Wales was 7.5% higher than that of the England and Wales average in 2019.

So we felt that we were -- we were nervous that we would not have enough allocation should there be a hundred per cent uptake, and in fact, for our care home residents and over eighties, we came fairly close with 98% on the first dose. But in the event, BEIS were always very generous in giving us the option, where there were vaccine batches that were approaching the end of their shelf life, we were often offered these, and accepted them gladly.

Q. And do you have any suggestions about what you say might

be a better way of approaching allocation in a future pandemic?

A. I think we need to make much better use of our statisticians, if I'm honest, to look at the population structure that will be targeted, and the order they'll be targeted, so that, for instance, if there's a need to immunise children, as opposed to the adult population, that those areas of the country with very young populations, so London, Birmingham, other areas, would obviously have more share, but on this particular occasion we were looking at the elderly and the clinically at risk.

Q. In terms of other types of engagement between the four nations, there were regular, I think from December 2020, weekly meetings --

A. There were.

Q. -- between the SROs?

A. Yes.

Q. There was also a WhatsApp group for more day-to-day quick communication?

A. Yes.

Q. Was that a useful, that package together of the meetings and the WhatsApp contact, a useful relationship?

A. Yes.

Q. And one which might be a good idea to repeat in the

event of a future pandemic?
A. Yes, definitely. The meetings afforded us the opportunity to involve our teams and to ask officials for more guidance. But the WhatsApp day-to-day conversations were an invaluable peer support mechanism as well, and a chance to be honest, and transparent and candid with each other.
Q. An issue arose between the nations as to a UK-wide vaccine delivery plan.
A. Mm.
Q. In your statement you explain that a draft version was shared by UK Government and SROs in each nation on 8 January with a request for review and contribution from Wales, Scotland and Northern Ireland. Was it possible for Wales to agree a joint UK plan at that time?
A. It could have been had there been earlier notice, but we were informed about it very late on the Monday before it was due to be published, and we only actually received the draft version in full on the Friday evening, by which time, obviously, that meant a very, very short space of time to consider it and no time for consultation.
It also meant that, you know, because, in Wales, we have a duty under the Welsh Language Act to produce

every public document bilingually, so to have put our own stuff in, and also translated all that had not actually yet been completely finalised, from the UK Government would have been incredibly difficult.
Q. In your view would there have been -- because Wales, of course, went on to publish its own strategy.
A. Yes.
Q. Would there have been benefit in a four-nations plan or given the different deployment approaches, was it sensible to have separate plans?
A. I think there would have been strength from a public confidence aspect to have had an overarching four-nations introduction, and then a section for each country, but as it was presented to us at that time, and I appreciate that, you know, the matter was pressing to get milestones for delivery out. However, it came across as an incredibly Anglo-centric document that I don't believe any of the four nations signed up to eventually.
Q. So presumably, if the scenario arose in the future, it's earlier collaboration and notice --
A. Absolutely.
Q. -- which would be helpful?
A. Yes.
Q. Moving on, then, to that Wales vaccination strategy,

which was first published on 11 January 2021.
A. Yes.
Q. I know that there were revisions to it, but this initial foundational document.
Perhaps if we could take a look, INQ000410079.
This the strategy itself.
And if we scroll down, please, to page 4, section 2, an "Overview of where we are now", it sets out the key areas -- if we could just come back out, please.
It sets out the key areas that the strategy is focused on: to work closely with the UK Government on supply, to make sure that there is a proper vaccination infrastructure, and keeping up to date and informed. It sets out the scale of the challenge: the biggest vaccination programme in history.
The strategy at paragraph 2 states that:
"It is important to be clear about the supply challenges ... the logistics around first vaccine in particular ..."
And that:
"Health boards are operating to a 'just in time' vaccine delivery mechanism as supply arrives."
Can you explain what was meant by that, please.
A. Yes. So we were very concerned obviously about the Pfizer vaccine's storage requirements and we had in fact

entered into an agreement with BEIS and Pfizer to have direct deliveries to Wales, and we were really, you know, finding out about that vaccine in the first instance.
But because the supply chain was very variable at that time, and if a -- supposing we had a batch that didn't receive approval by the MHRA, that could be half of our supply for that week. So we operated a system with all the health boards where they could order their vaccines and we would deploy them so that they were -- they had a continuous supply of everything we had, basically, coming into Wales. And that way it enabled them to deploy swiftly as well, whatever we were given.
Q. You mentioned a memorandum of understanding . Perhaps we could deal with that now.
A. Yes.
Q. That was a memorandum of understanding between the Welsh Government and BEIS in respect of delivery of the Pfizer vaccine. Could you explain in summary what that understanding was, what it allowed Wales to do differently?
A. It meant that our supplies did not have to go through Public Health England and it meant that they could come straight to Wales and be deployed immediately. There were very strict regulations on the amount of times

a vaccine could be moved, where it was to be stored, once it was constituted how long it could be used for -- 6 hours, for instance.

So cutting out the middle man, if you like, helped Wales to speed up our vaccination delivery --

Q. And was that particularly needed in Wales because some of the rural areas --

A. Absolutely, yes.

Q. -- being harder to reach and meaning that an extra transfer would make it unviable?

A. Absolutely, we just didn't have the luxury of that extra transfer.

Q. So returning to that document, please, at page 8, to briefly look at the model that was adopted. We see, just scanning here, that there is a plan for mixed delivery through mass vaccination centres, primary care surgeries, and mobile units, and an aim to have one vaccine centre in each county of Wales, and recognising that local convenience is served by reaching communities through primary care, and that's also safer for older and vulnerable groups?

A. Yes.

Q. At this point, 100 GP practices had been engaged and there were plans to get up to 250 before the end of January, and you also mention the importance of

community pharmacies.

If we could look at page 9, please, this the mention, at the top of the page, of mobile units; were they already being used in order to reach --

A. Yes.

Q. -- care homes --

A. Indeed.

Q. -- and other vulnerable groups?

A. Yes, and shortly after this strategy was published, by 26 January, we had over 300 -- well, 387 GPs came on board, 33 hospitals, 38 mobile teams and 52 mass vaccination centres, and that represented 9% of the population being covered with their first dose. And we also had a particular target to immunise all 16,000 of our frontline Welsh ambulance staff as part of the essential infrastructure resilience for the NHS.

Q. We see there as well reference to how appointments are made. In Wales was it the Welsh immunisation system --

A. Yes.

Q. -- for scheduling appointments and also recording and reporting on vaccination activity, was it all in one system?

A. It was an integrated system developed at haste by the National Wales Information Service, now renamed, but a lady, Jill Davidson, and her team, worked nonstop

really, basically, through a whole weekend and week to convert our child health immunisation system, which was an integrated call/recall, et cetera, and data capture system, and adapt that for the whole of the adult population in Wales.

Q. So this was operational at the time of the publication of this document which was 11 January?

A. Yes.

Q. And how effective was that system in particular in allowing you to monitor uptake and any gaps in uptake, in particular groups?

A. It was extremely helpful, and it enabled us to look at each health board's performance in terms of their areas, their GP clusters, for example, local networks of GPs, their gender, their age ranges, their categories, what cohort somebody was in that had been immunised, and then later, as we were able to develop better systems to look at ethnicity and other protected characteristics, it enabled us to have an enhanced vaccination report, enhanced from the daily so that we were able to look at areas that may be doing very well, or not doing well with particular groups.

Q. Thank you. We can take that document down.

The strategy, we needn't go to the page, but it also states that at that point, there was only 1% of wastage

in the first few weeks of the national vaccination programme, and you go into some detail in your statement about the fact that it's your view that Wales maintained extremely low levels of vaccine waste.

A. Yes.

Q. How was this achieved in Wales, please?

A. We had a pharmaceutical team with very extensive training in the use of the vaccine, and in supporting health boards. So every hospital pharmacy team was involved, every health board had pharmaceutical leads. So our team in Welsh Government would work with them to make sure that the vaccine was constituted correctly. Many of our mass vaccination centres, or all, in fact, I think had pharmacists on site so to ensure good preparation.

We also had systems so that at the end of the day, we had end-of-day doses and we had reserve lists, we had also a means of not unbottling and reconstituting vaccines that did not -- were not going to be needed. So about an hour from the closing centre times, the management of the centre would look at the queues, would make sure that the number of vaccination stations -- because there could be, say, 30 in a large centre -- that they were slimmed down to maybe five, you know, and below. So just for the last half hour we were actually

only opening exactly what we needed. We may have maybe three end-of-day doses but at the beginning, obviously with large numbers coming through, we realised that this was a distinct risk.

Q. Moving on now to the issue of equity of uptake of vulnerable groups, Wales had a dedicate surveillance programme designed by Public Health Wales to track inequalities; is that right?

A. Yes.

Q. If we could have up on screen, please, INQ000182538.

This is the Vaccination Equity Strategy for Wales.

A. Yes, this was written by -- actually written by a registrar on placement with us, who I was supervising and who did a fantastic job, actually. She was from a background of inclusion health.

Q. And published in March 2021.

A. Yes.

Q. Could we go to page 6, please. This summarises the position emerging from some of that research conducted, I think, by Public Health Wales, or certainly teams within government. If we look at the third or fourth paragraph down:

"In Wales there is emerging evidence that attitudes to vaccination are impacting on uptake of vaccination in some groups."

What was identified was an inequity gap in uptake between people who lived in the most deprived communities in Wales compared to those who lived in the least deprived communities, and the vaccination uptake gap is even starker when comparing uptake in minority ethnic groups compared to people of white ethnicity. In the over 80s, there is a difference 14.1%, we see there, compared to -- sorry, as compared between those from black, Asian, mixed and other ethnic groups.

Thank you. We can take that section down.

It perhaps goes without saying that from a public health perspective these disparities were not a surprise to you or to the other teams involved in this work. Do you agree that they were foreseeable, before rollout began?

A. Yes, they were foreseeable, because we had seen them with our influenza programme for adults as well. The only programme that seemed to achieve true equity in Wales prior to this, we knew that school nurse-based delivery of the school leaving booster for children was much more equitably distributed because that was a universal service.

Q. What is your view of the underlying causes for this situation in Wales?

A. I think it's not unique to Wales, but trust in the

government is extremely important, trust in the clinicians and the medical professions, transparency over safety, and are there any concerns are really important. I think there are traditional vaccine indecision over: is this vaccine safe for me? Is this vaccine forbidden for me because of my religious or cultural view? And is this vaccine accessible to me? And, you know, basically there's a whole gamut of factors which will apply differently to different individuals, but certainly, building up trust outside of a national crisis is something that is a precursor to good healthcare and good, sort of, receiving of healthcare, allowing yourself to be vaccinated during a pandemic. It's very difficult to fix in a crisis what is damaged in peacetime, because you do not have the luxury of time to build up relationships.

So we tended to use our trusted community leaders and networks, our existing framework such as, you know, our disability forums, our black and ethnic minority engagement groups in Welsh Government. And we had very good relationships on our stakeholder forum, which was, you know, sort of originally part of the board and then split off to have its own discussions. And out of that grew the Vaccine Equity Committee.

Q. Yes, that committee was set up and held its first

meeting on 22 March 2021.

A. Yes, but all of the stakeholders would have been involved since June 2020.

Q. 2020. Looking, then, at the plan and the actions taken during the pandemic, I appreciate you're saying that it's better for these relationships to have been established beforehand, but in terms of what was done both following on from the report we've just seen and after the Vaccine Equity Committee was set up, did the work focus on particular groups or those with physical sensory and learning disabilities --

A. Yes.

Q. -- mental health patients and people who may have substance misuse issues or be experiencing homelessness, people with uncertain immigration status, members of ethnic minority groups, and also residents in areas of economic deprivation? Were those groups the focus of the work?

A. Yes, and that's all outlined in the Vaccine Equity Committee action plan, and they had four groupings, really, with clusters of third sector community representatives working with the health boards on the best way to actually reach their communities.

Q. The detail of that action plan I won't attempt to list now, of course --

A. No, okay.
Q. -- it wouldn't be proportionate, but examples: ensuring information was available in different languages, providing translation services, ensuring information was in accessible or in Easy Read format for people with disabilities?
A. Yes.
Q. Community transport options, pop-up centres, use of trusted voices in communities to spread information.

To add to that list, just a couple of matters I want to ask you in more detail about. Within the list is reassurance for people that their information would not be shared with immigration authorities --
A. Yes.
Q. -- if that might be a barrier to them seeking vaccination.
A. Yes.
Q. Can you explain, was the situation the same in Wales as in client for people with uncertain immigration status when it came to the charging provisions that might apply to healthcare?
A. No. I think it's fair to say that Wales never subscribed to the hostile environment policy in that sense of ensuring that our data -- our clinical data on the patients was never shared with the Home Office. We

never entered into a data-sharing agreement. In fact we opposed it in Wales, I believe.

In terms of the vaccination programme, we liaised with Doctors of the World and their work and we attended their meetings that were happening on a national basis.

Wales had declared that it would -- has an ambition to be a nation of sanctuary, so there was a "welcome to Wales" website with signposting, but also there was a series of meetings, about six meetings in fact, with the Home Office, with the Home Office accommodation suppliers, with third sector groups representing migrant health, and all health boards and Public Health Wales, Welsh Government.

So there were -- troubleshooting of ways and means to encourage people to come and be vaccinated.

There was still a lack of vaccine confidence, especially amongst those that perhaps had not come directly to Wales, but I do believe that the various agencies together made a really helpful impact for that group.
Q. To be clear, the vaccination programme and treatment for Covid-19 was, of course, exempt in England from those --
A. Yes.
Q. -- charging provisions, but the difficulty was that there are concerns that that message didn't get through

to people or that they may have lacked confidence in information -- that in -- their information wasn't going to be shared, as the government had assured them it wouldn't be.
A. Yes.
Q. So are you confident that in Wales enough was done to let people who had uncertain immigration status and might be worried about that know that it wouldn't apply?
A. There's always more. There's always more that can be done. But particularly, you know, the fact that things like -- you know, people with maternities are very nervous, if they've been in England first, that they will be charged.

So all kinds of layers of misunderstanding that the four NHS systems are not actually identical can arise. So we tried our hardest to address those issues.
LADY HALLETT: I'm sorry, I couldn't quite hear and I don't think the stenographer did, either. People with?
A. Maternities, for instance, people who -- people are very concerned that if you are an asylum seeker you might be charged for your hospital treatment if you have a maternity.
LADY HALLETT: I'm so sorry, I'm not following. If you have maternity?
A. If you have a baby in a hospital, will you be charged,

basically.
LADY HALLETT: Oh, I see.

I follow. Thank you.
MS STEPHENSON: Just one other point of difference I want to ask you about when it comes to care. In Wales, was there a requirement to be registered with a GP or to have an NHS number in order to obtain vaccine?
A. No.
Q. A particular challenge in Wales was rural communities. What steps were in place to ensure that they had proper access to vaccines?
A. All of our health boards have been working with their rural communities for many years. Our NHS is fortunate in that we haven't had a reorganisation since 2009. So in fact, you know, our health boards know their communities very well. They've worked very closely with their general practitioners and other primary care contractors, and with community health services.

So, for instance, when the Pfizer vaccine arrived and came in trays of, you know, just under a thousand doses, then we were delighted that some of our GP clusters volunteered to, you know, do a vaccination weekend together. So, for instance, we had the Lleyn Peninsula in North Wales GPs, we had the Denbighshire GPs, we had the Bridgend GPs. All, you

know, giving very innovative cluster delivery, which was new. That was completely new.

So our health boards worked very closely to make the most of the resources in their area.

Q. And finally, there were some people for whom the prospect of attending a mass vaccine centre might be worrying because they have clinical vulnerabilities.

A. Yes.

Q. Which make the fear of infection particularly acute for them, and may make, in fact, using public transport or getting to vaccination centres difficult. What was done in Wales to accommodate those who might be clinically vulnerable so that they could access vaccines?

A. We worked with members of those communities to ask what would be helpful. In response, sometimes the vaccination was delivered in an outreach format. So for instance, with substance misusers we worked with agencies to deliver vaccine closer to the ground, for those with chaotic lifestyles that would not be able to keep appointments. We also worked very closely with our learning disability third sector organisations and representatives so that we had learning disability nurses in our clinics if we had, for instance, individuals with autism that needed particular treatments, areas, and quiet spaces.

And some of our nurses, you know, would go to the car and talk to the person and help make them feel at ease first. So we also had drive-through vaccination, actually, which, if people preferred that. They could access. And of course our GPs knew their patients very well, and were able to accommodate those that were worried about going to a public place.

Q. Moving on, then, to some issues which concern Wales being flexible in its deployment plan when it came to the way that JCVI advice was implemented.

A. Yes.

Q. You explain in your statement that Wales at one point permitted commencing invitations to the next JCVI priority cohort group when at least 50% of the cohort group above had been invited. Can you explain how that worked --

A. Yes.

Q. -- and whether that is a correct summation of what was happening?

A. Not quite, because 50% of the cohort had to have been immunised, actually, and the rest of the cohort had to have been offered appointments. And at that stage, they could -- to avoid the lag that sometimes happened in between cohorts, they could get ahead on the next cohort and start inviting them.

Q. You've talked before about Wales being a little ahead. Is that part of what sped things up in the early stages?

A. Yes, yes, indeed. But also the fact that we were really promoting the immediate use of our stock and, you know, querying whether there should be any stock, actually, in freezers or fridges because really it should be in arms as soon as it arrives.

Q. Was there a danger in doing that, that there would be fewer available appointments for those in the higher priority cohorts who should have been getting it first?

A. No, not at all, because the requirement was that they had to have been offered their appointment.

Q. Another area of flexibility, perhaps, is the guidance on unpaid carers.

A. Yes.

Q. And so the clinical advice group that we've referred to a number of times offered advice on the definition of unpaid carers and interpreting JCVI's definition.

A. Yes.

Q. Wales amended their approach slightly. How did they do that?

A. Yes.

Q. How did you do that?

A. Having consulted with our ethics and advisory group and our vaccine clinical and prioritisation group, there

were some concerns that the definition of unpaid carers needed to be slightly more flexible. In particular, if there is an unpaid family carer for a vulnerable family member, there's often two people, at least, who will be looking after them in a very close way because no one person can do it 24 hours.

So basically, our unpaid carers were invited to come and to self-identify. We obviously knew of some that were in receipt of DWP or local authority registered. They may have been known to their GPs but many others were not and were hidden unpaid carers. So we asked all our health boards to promote a central portal on Welsh Government where people could self-identify and the health boards would then get in touch with them and send them appointments. And the Welsh Government published guidance on 24 February about this to publicise it so that each health board had this local implementation inclusive approach, working closely with their local authorities, because obviously we have that benefit of the very long relationships in our structures with local authorities.

Q. And did you find that that led to a flooding in any way of the system, of more people than perhaps were suspected to be unpaid carers self-identifying?

A. No. No, I think it was about right.

Q. There was also a flexible approach adopted on the JCVI guidance around learning disabilities --
A. Yes.
Q. -- and the distinction between people with a severe and profound or mild or moderate learning disability. Did the Welsh Moral and Ethical Advisory Group advise on that issue, and what was the outcome?
A. They did, but we also had learning disability charity members on our stakeholder forum and on our Vaccine Equity Committee. So there were a variety of sources of advice on that, including from members with learning disabilities themselves.

We obviously were needing to implement the advice of the JCVI and keen to implement it. Individuals with Down syndrome were going to be vaccinated in cohort 4, but others would be immunised in cohort 6. But the classification of disability is not -- is not framed, as the guidance came out from JCVI, in terms of the public or in terms of the learning disability registers, for instance, that our GPs maintained to exercise their annual checks on those with learning disabilities. We've had that for some years, including also those with serious mental illness.

So we decided that, again, we would have a permissive approach. Our minister was at pains that

no one was to be left behind, and it was very difficult to strictly define who was severe or profoundly learning disabled.
Q. So it captured anybody, then, with a learning disability?
A. It captured anybody that we could identify as having a learning disability, and we knew that even for those with mild to moderate, there were much poorer health outcomes, for instance, just generally in terms of their healthcare.
Q. A different topic entirely, please: Vaccination as a Condition of Deployment --
A. Yes.
Q. -- which of course was not implemented in Wales.
A. No.
Q. That was a ministerial decision?
A. Yes.
Q. But it's one that you had some input to because you contributed to a Cabinet briefing paper in 2021 about the advantages and disadvantages of the approach. Can you explain, please, why Wales did not go down that route?
A. Yes. It's interesting, earlier on in the week Heidi Larson talked about the fact that making smallpox vaccination mandatory actually led to the first anti-vax

movement, because people resented coercion, and so it sort of -- that's the context in which perhaps I'll frame this, but we had very high uptake rates, actually. By 24 June, we had 92.5% of our care home workers had had their first dose, and 86.5% had had their second dose.

The social care working group of SAGE advises 80% coverage for care homes, and our lowest health board coverage was actually 89%, so -- with our highest being at 98% dose 1, 94% dose 2.

So we could see that there was a challenge for some areas, particularly in London, and we did feel that, you know, it was very difficult for colleagues in England, but for ourselves in Wales, we did not feel that we needed it. We felt that the emphasis should be more on giving information, helping to assure any that had concerns, and also on enabling and requesting that the workers in care homes who are often quite lowly paid, were able to have a vaccination in work time, not in their own time, when they may have childcare responsibilities, when they may have other issues that would impact on them.

So we felt that it would need to be continuously monitored because the workforces are very rapidly changing, workforces are high turnover, but our Chief of

Social Services, our Chief Medical Officer, regularly wrote to the care sector to, you know, encourage them, to continue with this extremely high level of take-up and to congratulate them, really, on that.
Q. Why do you think that Wales was able to achieve that higher level take-up amongst care home workers in particular?
A. Our very first initial strategy had set out that we would -- we aimed to immunise our care home workers at the same rate as our care home residents, because it was an environment in which we needed to protect everybody. In particular to make sure that carers didn't come in to work and infect the residents.
Q. Moving on, VDPS, please.
A. Yes.
Q. Which was, of course, a matter reserved to the UK Government. But are you able to give your views on --
A. I am.
Q. -- how that scheme operated in Wales?
A. Yes. Obviously it's not a devolved matter, and the Welsh Government, this was not their opinion, but my own personal opinion is that any scheme that looks at compensation needs to be a sliding scale and not a threshold. It needs to be very responsive and it

needs to take into account damage that has occurred for which somebody has worked very hard to rehabilitate from. So, for instance, if somebody is in a coma for six months, and then recovers and has 49% disability, there is no compensation for the time that they were completely unable to work, support their family, be involved with, you know, loved ones, et cetera.

So it's very important that if we're calling people to accept a vaccine -- which we believe to be safe but may have a miniscule, you know, four in a million chance of having a very serious side effect -- that we support those that have the very serious side effect. And I think we saw the effect on the impact video that not having a scheme that seems empathic, that seems understanding and accessible, and that gives reasonably, you know, responsive timeliness in its decisions is extremely important.

Q. I perhaps ought to clarify that it's not a compensation scheme, which I think is the language that you used. But you have explained your own personal views on the effectiveness of the Vaccine Damage Payment Scheme.

A. Mm, mm.

Q. The MHRA Yellow Card Scheme --

A. Yes.

Q. -- of course operated in Wales.

A. It did.

Q. What was your view on the effectiveness and the awareness of that scheme? And by "effectiveness", I'm not asking you to comment on safety matters, but in terms of the deployment perspective, whether people who were receiving vaccines were sufficiently where of it?

A. It's a scheme that works in peacetime. I think in a crisis, we needed a more enhanced active surveillance, in actual fact. The problem is that although the MHRA may have been seeing reports -- if the reports indeed were sent, because many members of the public are not aware of the Yellow Card Scheme, and junior doctors in training, you know, are told about it but may not be experienced in its use, so I think seeing other reports on an active map of reports of strange, rare events, would help clinicians to put the pieces together themselves.

I think that the MHRA did a fantastic job in keeping the public informed, but this particular scheme is probably one that needs refreshing or repromoting. I think that the introduction of an app that you can report on is a really good step, and that's been taken.

I think earlier alerts on possible signals to clinicians is needed, and an enhanced surveillance. And an example of that might be the enhanced surveillance

that took place when we initially had our Covid cases. So we have a high consequence infectious diseases policy. Everybody knows what to do if they get one of these HCID cases. And the UKHSA gives monthly summaries of global HCID events. So there is a global surveillance mechanism for it as well.

I think the other thing about high consequence infectious diseases is that there is referral to specialist centres so that expertise can be gained by a very few specialist centres.

And in the case of those who had had vaccine damage, I think this might have helped with learning. We talk about the first hundred cases, you know, of an HCID being where you learn. And obviously, with the rate that these were happening, that would have to be global, but to have some, you know, pooling of expertise in the rapid identification and treatment of anything that could be, for instance, a cerebral venous sinus thrombosis, with thrombocytopenia, would have helped clinicians to learn more about management.

Q. And just finally, what information, please, in summary was available to people who were receiving their vaccine, in terms of safety? Was there a protocol in place in Wales to set out what they needed to be told so that clinicians --

A. Yes, there was. There were detailed protocols of, you know, standard operating procedures for our vaccine delivery, and every patient received a patient information leaflet.

There were also other sources where they could go to for advice on safety, and every member of staff was trained to have those conversations. And in fact people were encouraged to discuss with their healthcare professionals any concerns before they accepted the vaccine. Then we kept on with the 15-minute wait much longer than everybody else, until the temporary authorisation to suspend it went, and it was permanently suspended. And at that time, having observed that it had been safe for the rest of the UK, we did abandon our 15-minute wait as well.

MS STEPHENSON: Thank you. Those are my questions.

LADY HALLETT: Thank you very much, Ms Stephenson.

Mr Dayle, I don't know how much Ms Stephenson has left you of the questions I've agreed to. But ...

Questions from MR DAYLE

MR DAYLE: [Microphone not switched on].

Right, I'll try to do this without the -- right.

Given the pre-existing research and evidence of lower uptake of vaccination programmes, generally, amongst ethnic minority groups as you've spoken about,

do you accept that the disparities in uptake of the Covid-19 vaccine were foreseeable, and ought to have been anticipated with active mitigation incorporated into the planning and decision making around the vaccine rollout?

A. I agree.

Q. And thanks for that confirmation. And in your paragraph 237 of your statement, in discussing mistrust about the vaccines, you said, and I quote:

"The fears of members of some ethnic minority groups such as some Asian and black African individuals was in my opinion a result of mistrust of authorities based on past and present experiences, including the history of European colonialism and slavery."

And just put that in the background for now, considering that the core message for vaccine uptake was that the benefits of taking it far outweighed the risks.

So, holding those two things in mind, my question is: how does the historical mistrust between black, Asian and minority ethnic communities and authorities, such as you've described it, affect the ability of that core public messaging on vaccines to resonate within these communities?

A. Thank you. I think it's very important for that message to be transmitted by the right messenger. So it's very

important to involve trusted voices. So, for particular faith-based communities, or for particular cultural or ethnic minority communities, Gypsy, Roma, Traveller communities, for example, as well, it's essential that the messenger is trusted and so the use of healthcare professionals from those backgrounds, the use of trusted community leaders, the extremely helpful advice from the central -- for instance, The Muslim Council of Great Britain, on the fact that the vaccine was permitted, it was halal, was extremely helpful, and similarly for advice from Jewish bodies as well.

So we do need to work much harder in peacetime to make sure that we have a distributed communications mechanism using the voices that people in the communities we know and anticipate are going to have lower uptake are based.

MR DAYLE: Very well. Thank you.

LADY HALLETT: Thank you, Mr Dayle.

Thank you very much, Professor Richardson. As you said at the beginning of your evidence, it was a team effort to deliver the vaccines around the country.

THE WITNESS: Absolutely.

LADY HALLETT: And obviously we're very grateful to all of them and to you for the part you played in delivering the vaccines.

THE WITNESS: Thank you.

LADY HALLETT: Thank you very much for your help then and for your help to the Inquiry.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: I shall return at 1.45.

(12.46 pm)

(The Short Adjournment)

(1.45 pm)

LADY HALLETT: Ms Stephenson.

MS STEPHENSON: My Lady, the next witness is Dr Naresh Chada. Please can the witness be sworn.

DR NARESH CHADA (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Dr Chada, apologies for the delay in getting to you.

MS STEPHENSON: Please can you say your full name.

A. Yes. My full name is Dr Naresh Kumar Chada.

Q. Dr Chada, thank you for attending today to assist the Inquiry.

Just some preliminary matters. You made a witness statement, dated 28 October 2024, INQ000474476. It runs to 55 pages and contains, at the end, your signature and a statement of truth. Can you confirm that you have had opportunity to read that statement recently and that its

contents are true?

A. Yes, I can fully affirm that, yes.

Q. Thank you. Touching briefly on your professional background, you have a medical background with a specialism in public health; is that right?

A. Yes, that is correct.

Q. And you held the position of Senior Medical Officer in the Department of Health in Northern Ireland from October 2001 to March 2019, and were you then appointed to the post of Deputy Chief Medical Officer of Public Health in April 2019?

A. Yes, that's correct. I've got a background in public health medicine and I was in the department for that time before I became Deputy Chief Medical Officer.

Q. And from March 2020 to October 2020, as part of your role, did you provide clinical input for vaccination-related issues, standing in, at that point, effectively, for the Senior Medical Officer, and act as lead for vaccinations and health protection?

A. Yes, I did.

Q. You then took on the role of Senior Responsible Owner for vaccinations in Northern Ireland. How did you come to be appointed, please?

A. Yes, well, I think in the time leading up to that role we were sort of aware that there was going to be

a vaccination campaign, you know, depending on whether vaccines were going to be approved or not and able to be used and we perceived that was going to -- it was perhaps going to happen at the end of 2020 if things went correctly. So up until that point, I was involved in sort of setting some of the groundwork around that. So basically, I was getting involved with some of the groups, you know, the UK level that were involved in laying the groundwork for the vaccination programme. And then, also, as Deputy Chief Medical Officer, I was, you know, very much involved in the Covid response on a number of different areas, and because I'd also been advising on vaccination, it was felt that I would have the necessary experience to be able to contribute to the Senior Responsible Officer group, and be the representative for Northern Ireland on that, and indeed fulfil that role.

Q. Once you took that SRO role, what were your responsibilities?

A. Well, I had a number of responsibilities. First of all, it was largely around making sure that I worked effectively with the Senior Responsible Officers in the other four devolved administrations.

I was very, very, you know, keen that, you know, there was proper policy co-ordination that was going on,

and I wanted to be able to contribute to that and as well as communications as well. I also wanted to make sure I had proper oversight of the programme that was happening in Northern Ireland as well, so just to make sure that we were starting the planning around that and how we would deploy the vaccine.

So as well as myself, we appointed a vaccination operational lead who was Dr Patricia Donnelly, and then she worked with me and a relatively small core team of people in the department to try to get the vaccination programme up and running.

Q. So you worked closely with Dr Patricia Donnelly. Can you just explain a little more what the division of responsibility was?

A. Yes, certainly.

Dr Donnelly is a very, very experienced and well trusted leader of the health service in Northern Ireland, and she has an awful lot of operational experience as well, so we felt she had the right skill set to actually make sure that the vaccine was planned for and deployed effectively. And basically, my role was to have oversight of what she was doing, make sure that that was, you know, fully communicated to the governance procedures that were going on in Northern Ireland at that time, and also, I would then be

able to free Patricia up to be able to deal with the issues that were happening at a UK level, such as the other Senior Responsible Officers have talked about today.

So it was, I think, two roles that were both complementary and quite distinct, but really worked quite well together for, you know, the small infrastructure that we had in Northern Ireland to be able to do that.

Q. Can you give us an idea in overview of what the role of a public health authority in Northern Ireland was and how they fitted in?

A. Yes. So, in Northern Ireland we have a single agency who are involved in the issues relating to public health and the implementation of public health policy in Northern Ireland. So they work across the three domains of public health, which, you know, includes, you know, primarily health improvement, but health protection is a big part of what they do as well, and also inputting into service development.

The Public Health Agency has, you know, historically always been involved, or ever since their inception, in ensuring they implemented vaccination programmes in Northern Ireland, so the routine vaccination programmes such as those that -- you know, for example, the

childhood vaccination programme, seasonal flu, et cetera, et cetera, they would be involved in that.

I think for this programme we decided that we would have a bit more central control within the department for the programme because, obviously, it was the biggest public health intervention that had taken place, not only in Northern Ireland, but across the UK, you know, probably since living memory. And we also wanted to make sure that we had very, very responsive governance structures, so that obviously we had a Covid-19 vaccination deployment group within the department -- or the oversight group, group, rather. And then basically the Public Health Agency, their expertise was involved in a lot of key aspects of how that programme was then going to be implemented.

Q. Northern Ireland has a number of health trusts. We'll come to the issue in due course of what kind of delivery they could offer, but could you explain a little bit how they fit in, and what kind of independence, if any, they had over how vaccines were to be deployed?

A. Yes, well, the Northern Ireland trusts, the health and social care trusts, played a really, really key role in the deployment of the vaccine in Northern Ireland. So basically, they are integrated trusts. So not only do they provide health services but they also provide

social care as well, and that's something which is unique or unique-ish to Northern Ireland. So basically social care is provided in Northern Ireland through the health and social care trusts, and that integration, well, for the purposes of the vaccination programme, was very helpful and very important, because we were able to deploy, you know, for example, assets like community nursing, and, you know, domiciliary care into the programme basically, so it allowed us to have a much more community-focused and based, you know, programme as required, basically, because social care itself wasn't, you know, in a -- different agencies or, say, for example, in local authorities as it is in England.

Q. Turning to the issue of supply, which was, of course, something that was UK Government-led, but supply to Northern Ireland was based on the Barnett formula, which the Inquiry has heard a little about today, that there would be proportionate access to vaccines according to population size.

What was your view on whether that formula was effective for Northern Ireland?

A. Yes, I mean, we've heard quite a lot about the Barnett formula. I mean, I'm sure everyone's aware already, the Barnett formula is the methodology by which resources from central government are allocated to the devolved

administrations and that's a longstanding, you know, methodology which has been used, you know, for a variety of different things.

I mean, my view was that it was a very, very pragmatic way of doing things at the beginning, at the start. I mean, we needed a set of principles that, you know, the ministers could sign up to, and I think they all did that in early November.

We've used it for other vaccination programmes, and it's been used quite widely as a means of allocating the vaccines. I felt that the formula, even though it might seem a little bit rigid, I think there was quite a lot of flexibility built into the system.

So, for example, because of the cooperation that we had across the UK, it was always going to be possible for us to change and flex a little bit according to what individual needs were going to be in the devolved administrations, but I do accept that if you are going to get into the detail, there can be demographic differences between different parts of the UK. So, you know, certain parts of the UK have a much younger population, say, for example, and it is also very much dependent on what -- how you're going to prioritise vaccines as well, but I thought as a starting point it was absolutely fine.

And in fact we still use it in vaccination programmes today. So I don't think there was any major issues with it in Northern Ireland.

Q. The Inquiry has heard about weekly meetings between SROs for the four nations and that there was a WhatsApp group to enable quick communication between those SROs as well. You were part of that regular engagement. How effective, in your view, was the cooperation between the SROs?

A. Well, I think the cooperation between the SROs was very effective, and certainly I've got a very, very long career in public health where I've had to work with devolved administrations over that period of time on a huge range of issues, both to do with emergency planning or to do with health improvement and I have to say that this demonstrated for me, in my career, one of the most effective four-country working relationships that I had seen, and I was very pleased to be involved in that.

Q. I'm going to move on now to how deployment worked in Northern Ireland.

Was the vaccination programme effectively planned and managed by an oversight board based within your team, which first met in July 2020?

A. Yes, that's absolutely correct. We had a Covid-19

Vaccination Oversight Board, and I think one of the things that, you know, we've been reflecting on and learning is that it's really important to have effective governance structures which are not overly cumbersome and I think our oversight board achieved that. So it was chaired by the Chief Medical Officer, it had key people on it, obviously, you know, Dr Patricia Donnelly who was in charge of the actual vaccination deployment, there were colleagues from pharmacy, from communications, from the Public Health Agency.

So there was, I think, the expertise that we needed there, and, you know, we were then able to report directly through the chairmanship of the Oversight Board which was the Chief Medical Officer who, you know, was accountable for the programme and he was able to report directly up to the minister. So I think there's really, really good governance structures that were very, very slim-lined but also very effective as well.

And below that we had more operational and implementation structures as well. So I think for the purposes of Northern Ireland, it worked well.

Q. When -- the group you refer to below that, is that the Implementation Group led by Dr Patricia Donnelly?

A. Yes, that's correct, yes.

Q. And did that group report to the Oversight Board and

deal with matters like pharmacies, storage and distribution?
A. Yes.
Q. Communications, logistics, workforce?
A. Yes, yes.
Q. Practical, operational matters?
A. Yes, we would get reports on all of those areas to the Oversight Board and then the Implementation Group was much more involved in the day-to-day nitty-gritty of how they were actually going to get the programme up and running and then through all the various iterations of the programme as we worked our way through the different priority groups, basically.
Q. There was an effort, the Inquiry has heard, to create a joint UK vaccine delivery plan in those early days at the beginning of January 2021, jointly between all four nations. You explain in your statement that there wasn't time for devolved nations to contribute.
If we could, in fact, just look at your thoughts at the time, INQ000477804, page 15, please, at 13:52:25, if we could zoom in.
So the suggestion has been made there about feeding into this joint document and you were saying at the time to DHC:
"We really want to work towards a joint strategic

document and we tried to feed ... back as best we could on a very short timescale."
Could you explain, first, what the difficulties were -- we can take that down now, thank you -- which meant that you were expressing in this WhatsApp group to the SROs that you wanted to contribute but you just couldn't in the time available? What happened?
A. Yes, I mean, this particular document was going to be produced on behalf of, you know, the wider UK, quite early on in the vaccination programme. So, as you can sort of see from the dates there, you know, it was 10 January, so we were less than a month into the proceeded, and we also had the intervening Christmas period as well.
I think ideally each of the devolved administrations, and everyone has got their own particular view on this, would have liked to have been able to contribute a bit more fully to the document. So, you know, particularly in terms of some of the detail around their delivery plans or the number of vaccination sites they had, et cetera. But I think it was just because of the very, very tight timescale, perhaps the WhatsApp group demonstrated that perhaps it was a little bit disquiet about that and, you know, they just weren't able to put what they wanted to do -- you

know, put it into place as quickly as possible, as they could.
But nevertheless, I mean, you know, the document went out there. It was published. And I think at least very quickly it gave the public an idea of what was happening at a UK-wide level, you know, both in terms of, you know, the acquisition of the vaccine and what the ongoing plans were.
So, you know, for that moment in time, perhaps more could have been done to get contributions from the different devolved administrations.
I think my longer-term view is it probably didn't make much difference in the end, and yes, I think it is important, though, for us to have that collegiate view of things, and for obviously each of the devolved administrations to have their opportunity to be able to contribute, but I just think sometimes the timescales in that particular one just weren't sufficient at that time.
Q. Did Northern Ireland create a public vaccine plan or vaccine strategy document of its own?
A. Well, we certainly had a vaccine plan that we worked to from an operational level. I just can't recall at this minute whether we actually published one online, so to speak.

But what I would say is that we were always communicating to the public what our plans were for the vaccination programme in Northern Ireland, and how it was going to be deployed, and how we were looking forward to that. So whether there was an actual document I just can't recall just at this minute, but whether you look at what we were actually trying to do in terms of communicating openly, both with the public and indeed, you know, the wider society in Northern Ireland, I think we were very open about what we were doing around vaccination planning.
So, you know, there was communications obviously by Dr Patricia Donnelly, the Chief Medical Officer, the Chief Scientific Advisor. So people would have known very clearly what we were doing. And there was a lot of information about what we were doing around vaccination on the Northern Ireland website as well, NI Direct.
Q. There isn't such a plan exhibit in the documents that you have provided to the Inquiry.
A. Mm.
Q. On the basis that there wasn't a public-facing document of that kind, do you think in the future it would be helpful to pull together the information that you've talked about being available online and the announcements in a public-facing strategy document?

A. Yes -- well, I think communication generally is really, really important, because I think when you're carrying out a major public health intervention like this, which requires the organised efforts of, you know, both the public and, you know, wider society, it's really important to communicate what you're planning to do. So certainly I think, you know, not only, you know, verbal, oral communication, media communication, but I also think that a written document which is there and available for people to see is really important as well.

Q. I just want to ask you to look at one document -- INQ000276660 -- which may assist with an overview of the plan. You describe this in your statement as an implementation plan for the rollout.

A. Yeah.

Q. Lots of that information obviously is applicable to many nations -- or all nations, but if we see down the right-hand side, the delivery models that were in place -- this is in fact a May 2021 document, but does it represent the delivery models that were used: vaccination sites, seven centres aligned to trusts; trust mobile teams, going out to care homes and care home staff, that was completed by the end of February 2021, we see; GP practices; roving; a mass vaccine centre; and community pharmacy.

Is that a good overview of the plan that was in place?

A. Yes, I think so.

Q. Thank you.

A. And we worked from this visual depiction quite a lot and I think it's very, very accurate.

I also think that it demonstrates that we used a variety of methods in Northern Ireland to deploy the vaccine, so obviously the trust vaccination sites, the larger mass vaccination centres, the extensive use of primary care and community pharmacy, and then also the more nimble, flexible and agile things like, you know, mobile clinics and pop-up centres as well. So I think it demonstrates that very well.

And I think that's the sort of modelling or the models that were sort of deployed across the devolved administrations as well, but, you know, perhaps with subtle differences as to the mix of how they were used.

Q. Thank you.

And that document can come down, thank you.

You explain that, unlike other parts of the UK, Northern Ireland did not have a GP federation organisational agreement, and that affected the type of vaccine that could be delivered in GP practices. Can you explain what the issue was there, please.

A. Yes. Absolutely.

And I think in order to be able to understand that issue, and to some extent it's been covered previously, the vaccination that was, you know, originally approved was obviously the Pfizer-BioNTech vaccination, and it had to be handled very, very carefully, at ultra low temperatures. It could only be used or deployed in very, very specialist circumstances.

We have individual GP practices that are contracted in Northern Ireland to do vaccinations, and I think it would have been incredibly challenging for them, both from a technical and a governance point of view, to be able to use that vaccine.

Now, it was very fortunate that the AstraZeneca vaccine, which we expected to be approved quite quickly, was done so, and then that was then able to be used by the general practitioners in the first week of January. So they were then able to vaccinate clinically extremely vulnerable people and also people over the age of 80 and the housebound.

So basically, we did sort of, like, you know, what was an approach where we were using the trust-based teams to get out to nursing homes and care homes very, very quickly and in fact we were one of the first parts of the United Kingdom to be able to do that effectively,

because we had worked out the methodology of how to use the Pfizer-BioNTech within that context and then get mobile teams out to them and then very, very quickly we started to use -- utilise GPs just a few weeks later in order to deploy the AstraZeneca vaccine within both their practices and within their -- the communities that they were serving.

Q. So did the fact that the GP practices weren't able to use the initial authorised vaccine, Pfizer, did that slow down delivery at the beginning of the rollout in Northern Ireland?

A. No, I don't really think so because I think what we were trying to do was to focus on priority groups 1 and 2. So we were focusing on the care homes and also health and social care staff. And so basically we were able to vaccinate those people quite quickly, using the trust's centres. And then the GPs came online very, very quickly after that, and then they were able to vaccinate elderly people, and, you know, people that were more vulnerable, basically.

So I would say that we were -- I don't think our programme was particularly constrained by that. It was only just a matter of a week or two. And also, vaccine, you know, supplies were just coming in slowly. They were quite constrained at that time. So we were

focusing and targeting those that were most vulnerable, particularly the residents of care homes and the staff that were working there and health and social care staff in the system.

Q. And was the integrated health and social care system actually a real advantage when it came to care homes because you could very quickly deploy in those, perhaps, quicker than nations where there was an interface between social and healthcare?

A. Yes, I think it was helpful in that particular instance, because those assets of, you know, community nursing were able to to be utilised and also the trust-based teams were able to be deployed. They were deployed as mobile teams and they went out to the nursing homes and the care homes.

So, you know, we were in a situation where we had a much more flexible use of assets and we were able to bring in social care assets much more easily as well. So I think that was a distinct advantage that we had of the integrated social care system.

Now, other people may have other views about other aspects of that integrated system, but from the point of view of where I, as the Senior Responsible Officer, was sitting with a specific task to be carried out, I felt that it was incredibly helpful.

Q. You describe in your statement something called a twin-track approach. Can you explain what that approach was, that flexible approach to your cohorts?

A. Yes, I think it was something that we were using sort of early on in the programme, basically, and again, it was the division between who was being vaccinated in the larger trust centres and the hospital-based centres versus those who were being vaccinated in primary care.

So the twin-track approach was really about, for example, GPs knowing their patients, and, you know, being much more attuned to elderly patients. So they were vaccinating people in priority group 4, and the trust centres were then able to vaccinate people in the priority group that was just below that, basically, and they were to book appointments, I think it was the 65 to, sort of, 69-year-old age group.

So the twin-track approach was just basically, as you showed in the plan earlier, how we were able to use a variety of assets, both, you know, within the trust system, and in the general practice system, so basically, you know, people were being able to be vaccinated from, you know, cohorts that were very close together, priority groups that were very close together but maximising their use and the capabilities of each of those two systems.

Q. The military played a significant role, didn't they, in supporting one particular large central vaccination centre that wouldn't really have operated without their help, in your view? Was that the mass vaccine centre in Belfast which was able to vaccinate a lot of people very efficiently?

A. Yes, that's right. I think we've heard from others but certainly I would like to reinforce the point that the military were incredibly helpful in the vaccination programme, and in Northern Ireland the first mass vaccination centre that we set up was in one of our large entertainment arenas, which was called the SSE Arena. So we did use the MACA agreement, the military assets for civilian use agreement, in order to be able to deploy 100 people from the military who were combat medical technicians, and they were there, I think, from late March for a period of, sort of, six to eight weeks, basically, and they were able to carry out a variety of tasks which allowed such a large vaccination centre which, you know, had a throughput of approximately, you could vaccinate up to 6,000 people a day. So they were absolutely instrumental on that.

Q. On monitoring, there was no single IT system that was fully integrated to capture vaccination data in Northern Ireland before the pandemic; is that correct?

A. Yes, that's correct, in the sense that what we had in Northern Ireland before the Vaccine Management System, that we'll probably go on to describe in a little bit more detail, was that we had the childhood vaccination system, basically, and it would record all childhood vaccinations. And then we also had individual GP IT systems that would record vaccinations, and then the GPs would give, you know, returns back up to the department or the Health and Social Care Board in terms of the number of vaccinations that were done.

But yes, the point that I do need to emphasise is that no, we did not have a single vaccine management system in Northern Ireland, and that had to be commissioned and put together at pace, which we did.

Q. And are you now satisfied that that Vaccine Management System that was put together during vaccine rollout is capable of doing it what it needs to in terms of recording update and demographic information, that you're now in a better position than you were --

A. Yes, I think we are in a better position. First of all, I think it's important to emphasise that the Vaccine Management System was operational from day one of our vaccination programme, you know, which was 8 December. However, it did require quite a lot of refinement and development and improvement of its capabilities. But

that is not unusual when you put a major new IT system into place.

I think it's been incredibly helpful. It's still very much used, particularly in the adult vaccination sphere, so it's used not only for Covid but it's also used for -- you know, for seasonal flu and for other vaccinations such as RSV and shingles, et cetera, et cetera. So it's still there, and it's developed a lot of capabilities over that period of time, which have matured and which we still use.

And, you know, one of those is the analytics capability. So we are in a much better place when it comes to knowing, you know, who's been vaccinated in which geographical area, which age group, and, you know, certain demographic characteristics.

So I think it's put us in a much better place, you know, in a variety of different ways. So it's been quite a successful IT project.

Q. On inequalities, there was a Covid-19 Vaccine Low Uptake Working Group dealing with this area, with feed-in from the healthcare improvement team within the public health authority and the behavioural science team. The Inquiry has heard a lot of evidence about the kind of outreach measures which can be put in place to target ethnic minority groups, migrants, people experiencing

homelessness and deprivation who might have lower vaccine uptake.

Is the picture of those groups having lower vaccine uptake a familiar one in Northern Ireland as well?

A. Yes, it is. And I think one of the important points that I would like to make is that when you're dealing with vaccine equity, one size doesn't fit all, so, you know, the issues that you would have in Greater London are not the same as rural Scotland or not the same as Northern Ireland. So in Northern Ireland, one of the issues that, you know, we have to deal with is that, you know, we have some of the most socially deprived parts of the United Kingdom, so working on health inequalities has always been a big priority not only for the Department of Health but for the Public Health Agency as well.

So the low uptake group had to deal with issues that were peculiar to Northern Ireland, and the low uptakes amongst ethnic minorities was definitely something that they were very attuned to, but they also had to be attuned to things like social deprivation or various occupational groups with, you know, migrant people that worked in those, and, you know, some of the low uptake aspects of those. Rurality is a big issue in Northern Ireland as well, so we had to deal with those.

So the low uptake group I think targeted lots of different initiatives and targeted at lots of different groups, basically. So they worked with community groups, they looked at -- you know, they -- the particular challenges that were happening in rural areas, and they carried out specific targeted vaccinations, say, for, you know, certain occupational groups, such as fishermen and meat processors, and had some very, very successful uptake against those groups.

LADY HALLETT: Sorry to interrupt, I just want to check what you said, did you say morality was a big issue?

A. Rurality.

LADY HALLETT: Rurality? We were all puzzling and the stenographer --

A. Yes, sorry, pronunciation there. Rurality.

LADY HALLETT: I was just wondering whether Northern Ireland had another issue, though I couldn't think what ...

A. Yes.

MS STEPHENSON: You've given a couple of examples there, I'm not going to run through all the types of outreach that might be effective, but do you identify, looking back on the programme as a whole, whether there are any lessons learned, measures that might be taken in the future that would better address those communities with lower uptake and increase confidence?

A. Well, I think one of the most important things was, and we certainly improved as we went along, was to get good data as to what was happening in different localities, you know, particularly areas of deprivation. And I think that's something that we can refine in the future, but we were able to do quite a lot of that during the vaccination campaign.

I think also, when it comes to low uptake groups, it is important to work with those groups more specifically in smaller projects, and to try to get a bit more information as to what are the issues, what are the barriers, you know, what is it that makes people feel, say, for example, mistrustful of the vaccine, or maybe some of the really, really practical issues like: we can't get to the vaccine centre.

And we did quite a lot of that work in Northern Ireland during the programme but I think that's something that we can become a little bit more sophisticated and refined in the future. And I think that would not be only for Northern Ireland but obviously for colleagues right across the United Kingdom as well.

MS STEPHENSON: Thank you, those are my questions.

LADY HALLETT: Thank you very much, Ms Stephenson. I think -- Mr Wilcock. Mr Wilcock is just there, Doctor.

Questions from MR WILCOCK KC

MR WILCOCK: Good afternoon, Dr Chada.

A. Thank you.

Q. I'm asking questions on behalf of the Northern Ireland Covid Bereaved Families for Justice campaign. And as I suspect you know, many of the members of my organisation were concerned that vaccinated family members and visitors were not able to get into care homes on a more frequent basis to visit their loved ones whilst, simultaneously, unvaccinated staff could go into the care homes on a daily basis, and I think you'll be aware of that issue.

Professor Sir Michael McBride has identified it throughout the course of the vaccination programme. The department was conscious of the need to encourage healthcare staff to take up the offer of vaccinations. And the question I want to ask you arises from the fact that it's difficult for many of our members to understand why vaccinations were not made a condition of deployment for care home staff, and why vaccination status was not used to enable normalised visiting of family members in care homes.

So, to that end, the question is this: do you agree that there is a clear contradiction in approach, if unvaccinated healthcare workers could be employed to

care for care home residents whilst their fully vaccinated loved ones could not at the same time visit or provide care themselves?

A. Okay, well, thank you very much for that question. And as someone who also had a family member in a care home at that particular time, I fully understand the challenges that people faced and the stresses that people faced when trying to visit care homes. I think there's two separate issues here, which it's really important for me to try to disaggregate.

The first is about visiting policies in care homes. Now, as the Senior Responsible Officer for the vaccination programme in Northern Ireland, I'm sure you'll appreciate that the actual visiting policies themselves which were drawn up at a regional level were outside of my particular remit, so, you know, that is something that I can't really comment on in a huge amount of detail. All I would say is that, you know, from my knowledge, every attempt was made for the visiting policies to be as humane as possible and to take into account not only the care of the visitors but also the need for that social contact to be there for the residents of care homes as well.

But obviously that had to be done in order to protect people and protect the most vulnerable from risk

of infection.

The other issue you bring up is that of, you know, making it mandatory for people to be vaccinated, you know, particularly those that worked in the health and social care sphere.

First of all, as you will see from the vaccination prioritisation process, health and social care workers were prioritised very, very highly, you know, in priority groups 1 and 2, and that was for their protection, but primarily for the protection of the very vulnerable people that they were looking after. So there was very, very good reason for that.

I always personally believe that it is always better to try to persuade people and to make the arguments in a logical evidence-based way as to why you should be vaccinated and protected. So that is basically what we tried to do in Northern Ireland, and I think a lot of leadership was shown not only by the Chief Medical Officer, but the other chief professional officers, to try to persuade people to be vaccinated, particularly those working in the care home sector.

I think there is more that we can do in that particular sphere and I think it is really important for our health and social care workers to make sure they're properly vaccinated against these respiratory illnesses

and, not least, Covid itself.

So that's really the answer to your question. We need to make sure that we encourage as many people to be vaccinated as possible, who are working in these, you know, high-risk environments, and we also need to make sure that there are humane and equitable policies for people to be able to visit care homes which, you know, as I say, I wasn't directly responsible for at the time but, I believe, you know, changed and evolved and adapted as the course of the pandemic went on.

MR WILCOCK: My Lady, an answer has been given to the question. May I rephrase it, because I don't think it is the answer that the question actually deserved?

LADY HALLETT: Certainly, Mr Wilcock.

MR WILCOCK: Thank you.

You have explained the reasoning for the difference of approach. We understand that. Do you agree, however, that to the outsider, including many of the people I represent, the effect of the different approach does appear to be in contradiction to each other?

A. I'm afraid I would still be of the view that we need to do as much as we possibly can to try to protect the vulnerable people that are in care homes, and we need humane policies, or humane policies, I think, were attempted to be put into place for that.

I don't necessarily see that the two issues -- people could say that they are interrelated or connected. My focus as the Senior Responsible Officer in Northern Ireland for the Covid-19 vaccination programme was to make sure that as many of the population were vaccinated as possible, and uptake was as high as it possibly could be, particularly those that were working in the social care and the health sector.

MR WILCOCK: Thank you very much.

LADY HALLETT: I have the point, Mr Wilcock.

MR WILCOCK: Thank you.

LADY HALLETT: Mr Weaver.

Mr Weaver is right at the back there. Can you make sure when you answer him that you keep your voice going into the microphone, please.

Questions from MR WEAVER

MR WEAVER: Thank you, my Lady.

Good afternoon, Dr Chada. My name is Christian Weaver, I represent three organisations who comprise the Covid Vaccine Injured and Bereaved, and by way of context, those I represent include individuals who were injured after taking the vaccine as well as those who have lost ones due to its effects.

I have just a few questions, if I may, specifically on the topic of public messaging.

In your statement at paragraphs 197 to 199, you write as follows:

"With hindsight, I believe it may have been useful to take more time to clearly set out all the testing and safety procedures that had to be carried out in order to get the vaccines approved. This would include, from the outset, explaining why certain conditions are initially applied to vaccines which can then be subject to change as the programme rolls out and more data is gathered.

"198. Maintaining public confidence and trust was a guiding principle in a rapidly evolving environment, through openness and transparency while also carefully considering any changes to advice in order to avoid confusion.

"199. This was particularly important for very rare side effects which are not ordinarily detected in vaccine trials and only observed and reported once the vaccine is being rolled out to the general population."

My first question is this: you note that very rare side effects are only detected after rollout. With that in mind, how do you feel public messaging could have better prepared individuals for this possibility without undermining overall confidence in vaccines?

A. Yeah, thank you very much for that. I mean, I think it is really, really important for us to have, you know,

confidence in the vaccines, and I think, really, what I was trying to get at there, that, I suppose at the outset, it is important for people to try to understand how vaccines are developed, how they're approved, et cetera, et cetera.

And it's quite a complicated process. So, you know, obviously there's all the different phases of trials that go through and then there is the post-marketing surveillance that happens, say, for example through the Yellow Card Scheme.

So really what I was saying was that perhaps we just need to be a little bit more sophisticated in trying to explain quite complicated concepts so that the public has confidence in the vaccination programme. And I think that sort of messaging isn't necessarily easy to formulate, but what it actually does do is it -- if there are, sort of, simple messages that can be put out so that people have confidence in the vaccination, then at least it doesn't -- it allows people not only to be confident but also for misinformation not to be spread about how vaccines were developed as well.

So perhaps that's something that we perhaps need to think about a little bit more in the future, you know, particularly if there's going to be a very, very large public health mass vaccination campaign such as we've

just had.

Q. Thank you, Dr Chada.

My second question is this: do you believe public confidence could have been better maintained by pairing messaging about the rarity of side effects with clear assurances that support systems such as the Yellow Card Scheme and the VDPS were in place for those that may face an adverse reaction?

A. Yes, well, I think -- in terms of the Yellow Card Scheme, we're aware that that is the way that people report side effects of the vaccinations, and I think particularly for the Covid-19 vaccination programme, there were almost enhanced procedures that were put into place around that. So it was easier for health and social care professionals, and indeed the public, to be able to make reports of side effects.

Yes -- I mean yes, I agree, I think perhaps we do need to do a little bit more just in terms of educating the public about how those schemes work, and indeed then how that data is perhaps analysed and then communicated back.

But it's quite an important part of, you know, vaccination rollout, the surveillance is extremely important, so we do need to be able to pick up these rare side effects, make sure that they are properly

analysed by the MHRA and other analytical bodies, and then appropriate advice is then given out to people in terms of how we might need to alter certain advice around vaccines.

So it is a slightly iterative process, involving the use of data analysis and then the appropriate advice that comes out afterwards.

MR WEAVER: Thank you, Dr Chada.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Weaver.

That completes the questions we have for you, Dr Chada. Thank you very much.

Have you come over from Northern Ireland especially for the Inquiry?

THE WITNESS: Yes, I have.

LADY HALLETT: Well, thank you very much for all that you did during the pandemic, and of course your colleagues in Northern Ireland.

THE WITNESS: Yes.

LADY HALLETT: And thank you for all the help you've given the Inquiry.

THE WITNESS: Thank you.

LADY HALLETT: I hope you weren't -- I should have asked the witnesses from Scotland, were you affected by the storm?

THE WITNESS: Yes, we were quite badly affected by the

storm.

LADY HALLETT: I'm really sorry, I hope --

THE WITNESS: So, yes, some people very seriously affected. And I'm sorry for that. I had a few loose tiles blown off, so not so bad, thanks.

LADY HALLETT: You can live with a few loose tiles, but I'm sorry for any other damage and hope people recover quickly.

Thank you very much for your help, anyway.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: I'm not going to rise for the two experts.

MR KEITH: My Lady, the two experts from whom we're hearing this afternoon are Dr Ben Kasstan-Dabush and Dr Tracey Chantler. If they could be sworn, I'd be very grateful.

DR BEN KASSTAN-DABUSH (affirmed)

DR TRACEY CHANTLER (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4

MR KEITH: Could you please, both of you, commence your formal evidence by giving the Inquiry your full names.

DR KASSTAN-DABUSH: Benjamin Kasstan-Dabush.

Q. And Dr Chantler?

DR CHANTLER: Tracey Chantler.

Q. Thank you very much.

Thank you in particular for your provision of a very detailed, dare I say lengthy, complex expert report commissioned by my Lady, as you know, for the purposes of this module.

The topic and the subject of your expert report is Vaccine Delivery and Disparities in Coverage.

Is that a topic, an issue, a field, in which you are both expert? Perhaps you just answer one after the other.

DR KASSTAN-DABUSH: That's correct.

Q. Dr Chantler?

DR CHANTLER: Yes, that's correct.

Q. Dr Kasstan-Dabush, you are assistant professor in Public Health and Policy at the London School of Hygiene and Tropical Medicine, a lecturer in Global Health Policy at the University of Edinburgh, and your research focuses on vaccine inequity and related issues underlying what's described as lower level coverage among minority communities in the UK and internationally. Is that right?

DR KASSTAN-DABUSH: That's correct.

Q. And you've had many years of experience in this field, and over the years you've given considerable support to public health agencies in the United Kingdom and the US on, shortly, how to respond in the face of epidemics and

pandemics, and associated vaccination campaigns, but presumably also vaccination campaigns held routinely for childhood immunisation and so on, and on how to improve take-up and how to address the causes of disparity in take-up and barriers to access?

DR KASSTAN-DABUSH: That's right.

Q. Is that a fair summary?

And Dr Chantler, in your case, you are an associate professor of Public Health Evaluation, again at the London School of Hygiene and Tropical Medicine; is that right?

DR CHANTLER: That's correct.

Q. And you are what's known as a theme lead in the National Institute for Health Research, about which we've heard a fair bit, and in particular, its Health Protection Research Unit.

DR CHANTLER: Yes, that's correct.

Q. On the subject of vaccines and immunisation. And do you co-direct the London School of Hygiene and Tropical Medicine's Vaccine Centre, which is a collaborative partnership which operates here and abroad to try to assist with the delivery of immunisation programmes?

DR CHANTLER: That's correct.

Q. And was your report greatly assisted by other experts, both in the London School of Hygiene and Tropical

Medicine, in the form of Dr Sadie Bell, Dr Edward Parker, Professor Sandra Mounier-Jack and Professor -- no, I think that's it for the London School of Hygiene, but also two other experts, from University College London, Professor Helen Bedford and Dr Rahma Abdi?

DR CHANTLER: Correct.

Q. But the report is all your own work in the sense of the text and the prose and what is contained in it.

All right. I'm going to impose my own route map on you, if I may be so bold. We're going to focus on, firstly, the systems and processes in general terms across the United Kingdom, highlighting and only really identifying their most significant features and the most important differences between them.

Then we'll look at the general statistical overview of coverage sectorially by age, ethnicity, geographical region, and the like, and then we will look at the causes of disparities and the methods that were actually deployed to address those causes of disparities, but identifying only their most significant features and the differences between the four nations.

Much of the groundwork has already been done, insofar as we've heard a great deal of evidence from the witnesses already as to what processes and procedures were actually in play, and what was done. What we need

from you is to highlight their most significant features, with a view to identifying what can be done better next time.

Dr Chantler, we're going to start with you first, please, and the first section of the report, which is from pages 9 to 11.

I want you, please, to pick up or address some of the most significant features of this bird's eye view, which is contained in your report at the beginning.

Vaccine rollout processes form part, do they not, of what might be regarded as a complex cycle of affairs; is that right?

DR CHANTLER: Yeah, I mean in paragraph 11 we talked about the various, the parts of a rollout process and what's required in order for that to happen, and the key actors involved. Yes, it is complex, but you do need some clear lines of responsibility, and accountability.

Q. And in your report do you focus on the latter part of the process, chronologically, that is to say public engagement to drive demand, the implementation strategies to meet the demand, and the evaluation of that delivery process? So you're not concerned, of course, with procurement or supply chains, or workforce-related issues concerning how vaccines actually get to be delivered?

DR CHANTLER: We cover some parts of the workforce but primarily, as you've said, from the public engagement right to the evaluation of programme delivery, yes.

Q. You make a point at page 9 at paragraph 13, about centralisation. And before we get into the minutiae of each of the four nations, in general terms was there a fairly high degree of centralisation at least at the start of the vaccine delivery process, in reflection of the fact that procurement, supply, the general structures for messaging, communication and getting vaccines at least into vaccination sites was driven by the United Kingdom Government and then secondly, by central government in each of the four nations before focus turned to delivery on the ground?

DR CHANTLER: Yeah. I would say that is correct. Certain aspects of implementation were also initially quite centrally directed, but particularly there was a strong emphasis on creating alignment across the devolved nations and making sure that there was a consistent and coherent approach.

Q. Were you able to say something about whether there was a greater degree of centralisation in England by comparison, for example, to Wales?

DR CHANTLER: Yeah, in Wales, with their seven health boards they were very keen to ensure that the approach,

particularly taken to implementation, was directed from the local health boards. So the decentralisation started much earlier than it did in England.

Q. At paragraph 12, you refer to a table, and the table sets out the number of different bodies which were involved in this necessarily quite complex process.

Let's have a look at that chart. I think it's set out at the paragraph 21 on page 13.

Sorry, in fact it starts on page 11. You call it "Division of responsibility between stakeholders", we might suggest it's called "Bodies involved in this complex process", but you can see that a number of UK bodies, as well as devolved administration bodies, were concerned in various elements such as policy legislation, procurement, oversight of deployment, and at the UK level, there was input from a number of different bodies: Cabinet Office, BEIS, the Vaccine Taskforce, CMOs, and so forth.

And then at the operational level, that's when focus has to be paid to healthcare services. So NHS England, NHS Scotland, NHS in Wales, and Health and Social Care (Northern Ireland), the public health agencies in each country, and of course the system for the provision of specialist logistic assistance and primary care.

DR CHANTLER: Mm.

Q. So it's a bit like going down a tree, or perhaps going up a tree -- well, maybe going down a tree. You get to the point where at local level you've got to focus on the primary healthcare provision and the logistical and delivery aspects away from Edinburgh, London, Belfast, and Cardiff.
DR CHANTLER: Mm.
Q. Do you express views as to whether or not, at the beginning of this process, the important part by which vaccines were delivered, the important bodies by which vaccines were delivered, were properly and fully engaged enough in the planning?
DR CHANTLER: Mm.
Q. You refer at pages 11 and 12 to whether or not, in England, Public Health England was sufficiently involved in the planning for the procurement of vaccines and in the operational work done by the VTF?
DR CHANTLER: I think the point we want to raise in our report is that it's that formal responsibility. So we have, since writing the report, become aware that Public Health England, now UKHSA, were probably feeding into the Vaccine Taskforce meetings and providing input, but they formally didn't join that Vaccine Taskforce until September 2020, which, from our point of view, given that UKHSA and NHS England are -- those with the primary

responsibility for delivering routine vaccination programmes, feels there's an omission, and that expertise could be more formally included at an earlier stage in England.
Q. We have, since your report was prepared, received evidence to the effect that Public Health England may have been a member of the programme board of the VTF --
DR CHANTLER: Mm.
Q. -- which was one of the two emanations of the Vaccine Taskforce from May 2020. If that is -- if that does prove to be the position, would you regard that as a sufficient involvement in terms of being engaged in the pre-delivery planning?
DR CHANTLER: I think it's heartening to know that. I think it would have been better if they were involved in the formal taskforce overall, given that they are very responsible for routine, have the primary responsibility for routine immunisation programmes. So I think that, from my perspective, the earlier involvement, the better. But yes, it is reassuring.
Q. And from the standpoint of seeing how well set up the overarching process was, to what extent do you assess that the planning and the initial delivery of vaccines across the United Kingdom did benefit from learning from the H1N1 2009 flu vaccination programme, paragraph 15?

DR CHANTLER: I think what was key from the evaluation of the H1N1 pandemic plan was the importance of alignment and those points you've touched on already, making sure that the devolved nations have the same procurement processes, the consistent messages, the working very closely together. I think that was done very, very well.
Q. Was that H1N1 epidemic -- did it improve the collaborative links within the United Kingdom? So in the course of responding to H1N1, had each of the devolved nations worked relatively closely together, and therefore there was, to use a terrible modern expression -- was the learning embedded from the response to that earlier -- (overspeaking) --
DR CHANTLER: Yeah, I think it definitely was embedded in the response to the Covid-19 pandemic in that, kind of, focus on making sure that there's alignment across the devolved administrations, in the overarching points around the prioritisation, the procurement of vaccines. So those, kind of, high-level decisions that need to be made. There was -- there were differences, and I'm sure we're going to go on to look at that in terms of implementation and I think also consultation at the political level of the devolved administrations. I think there was some learning that could have been

taken on that wasn't taken on.
Q. And within that structure, was there a high degree of collaboration between each of the respective nations' public health agencies, and the bodies in London responsible for procurement, and the bodies in each nation responsible for delivery?
DR CHANTLER: I would say yes.
Q. And at paragraph 18 on page 11, you refer to the rapid allocation of sufficient financial resources. In general terms, do you note that the Covid-19 vaccination programmes in each of the four nations were particularly notable for the way in which they were funded by comparison to, perhaps, difficulties in funding associated with routine vaccination programmes?
DR CHANTLER: Yeah, I want to clarify on this point, what we're talking about here in terms of this additional funding is the funding -- that it became very apparent, in order to do additional outreach and to address causes of disparity in uptake, funding was made available to, you know, service providers, and this was quite different from routine programmes. So that was -- and this enabled these delivery of novel pathways, and for closer collaboration with community partners.
And as far as we -- we don't know for certain, but we're assuming that the Barnett formula would have been

used to make sure that that funding was equally available across the devolved administrations.

Where there is -- could be improvement there is embedding more evaluation to see how that funding resulted in interventions that improved uptake that could then be carried forward and used in the routine programme.

Q. Well, I was going to ask you about the processes for evaluating the effectiveness, the overall success, of the delivery programmes in each of the countries.

In general, is there actually in existence a process by which anybody can readily determine how successful a particular vaccination programme was beyond the statistical facts and figures concerning take-up? In particular, is it actually possible to evaluate how well an individual vaccination programme is able to reduce barriers to access and to improve take-up in marginalised and ethnic minority communities?

DR CHANTLER: There are ways of conducting these evaluations, and it's definitely something that UKHSA and NHS England are investing into, particularly trying to help also -- this is routine programmes I'm talking about now -- frontline providers and people within local authorities to conduct evaluations, so that that empirical evidence is available.

We're very -- I mean, this was done at fast pace in the pandemic, so -- and the evaluations weren't built in from the go, so you were looking a lot of the time retrospectively, which makes it more difficult, but there's an emphasis on trying to include more evaluation work in future.

Q. And so, in the context of the Covid-19 vaccination programmes, you're obviously able to point towards statistics which show a general level of uptake, and you can even look at statistics and discern the levels of uptake in subpopulation groups in sectoral areas, by age, ethnicity, geographical region and so on and so forth. But is it easy to say that particular way of getting into the community and formulating a tailored approach to delivery of vaccines works better than another one?

DR CHANTLER: That's where it needs to be built in from the start, so that you already -- in your design of your intervention you're already looking at: how can we, kind of, draw out causal mechanisms that might then be contributing to increased uptake? So that needs to be built into them from the start, and it's something that requires a mixed methods approach, where you're drawing both on statistical data but also qualitative data.

Q. Did that absence of fully functioning evaluative

techniques stop you and Dr Kasstan-Dabush from reaching a view on the effectiveness of the processes adopted in the case of Covid-19?

DR KASSTAN-DABUSH: Absolutely. I think there is a huge kind of difference in the quality of evaluations that were done, the consistency in which they were done, much more in England than, for example, the devolved administrations. So the ability to look broad level and understand this picture across the four nations in order to inform a UK kind of approach to the pandemic, it was a really quite limited.

And where this becomes very crucial is evaluating outreach approaches. We know across the four nations that there were disparities among particular minority populations. So to understand, well, how effective were those outreach strategies, what did we learn, what was trialled in one jurisdiction and how could that inform approaches in another, the ability to have that information in front of us wasn't -- we didn't have it. It was limited.

Q. So I'm now going to bowl a very hard ball to you. How is my Lady going to be able to look at this mass of information about the levels of take-up and what was done in practice to improve take-up, particularly in marginalised and other communities, and make

recommendations as to how take-up can be improved in the future and how barriers to access and disparities can be addressed, if we don't know which particular method that was used works better than another one?

DR KASSTAN-DABUSH: And the point in time, and which particular approaches were done and why that might matter. So, absolutely. I think in the context of Covid-19 it's using the information that's available, and trying to piece that together. A slightly patchwork approach, I'm sorry. Not the most efficient approach. But I think the learning for the future -- and I think what -- Tracey, feel free to jump in -- is a UK-aligned approach to evaluation of vaccination programmes, obviously that's going to look different because of the devolved organisation of health and social care, but some standards, minimum standard requirements for evaluation would be incredibly helpful.

Q. So you would invite the Inquiry, as part of recommendations about the reality of delivery and how to improve the systems for delivery in future, to make an additional recommendation that there'd be a better system of evaluating how it's all going to work?

DR KASSTAN-DABUSH: That sounds fair.

DR CHANTLER: -- (overspeaking) --

Q. Dr Kasstan-Dabush, we can then move on to a different

topic, which is prioritisation. Prioritisation was a matter, of course, for the JCVI, and it was applicable across the whole of the United Kingdom because of the different four nations approach to whether, by statute or by practice, each nation would agree to follow the prioritisation decreed by the JCVI.

And it's not really to do with delivery on the ground; it's more to do, of course, with the way in which, by age, stratification and clinical vulnerability, different cohorts were invited to come forward and be vaccinated, but there is an overlap.

So I wanted to ask you: in general terms, was there a plainly visible and appropriate basis for applying the age stratified, the clinical vulnerability approach that the JCVI did? Did they, within their own terms, easily justify the approach that they had taken?

DR KASSTAN-DABUSH: I think it was certainly rooted in evidence, yes.

Q. And was one of the great attractions of the approach that they took its relatively simple and pragmatic approach?

DR KASSTAN-DABUSH: Absolutely. It ticked the issue of risk and the issue of implementation, how to do this in a way that's efficient, effective, and that builds trust in the public.

Q. Other than by reference to certain specific groups, for example clinically extremely vulnerable or those with profound and severe learning disabilities in cohorts, I think cohort 6 or cohorts 6 and 4, there wasn't generally allowance made for ethnic minority groups, or socially marginalised or the vulnerable in the priority list. And the approach that the JCVI took was, if the tide comes in across the country as a whole, it will lift everybody up, in terms of reducing transmission and getting vaccines out there.

Do you think, in terms of the importance of addressing disparity and of addressing inequality, that was an appropriate approach to take?

DR KASSTAN-DABUSH: Absolutely, yeah.

Q. There were, obviously, a number of areas where the JCVI was concerned about the impact of its approach. So, for example, the homeless, pregnant women, those who live in socioeconomically deprived areas, and also, to a large extent, disabled groups. No specific provision was made generally for any of them. To what extent do you think that the JCVI's approach appropriately took care of those groups?

DR KASSTAN-DABUSH: I think it was quite clear that there was a continuous process of trying to think this through, and ultimately, the decision was made that

implementation strategies would be the most effective way to address the vulnerabilities in particular cohorts, again, for example, ethnic minority populations. Obviously, those groups that you mentioned, such as clinically extremely vulnerable, would have a different priority status.

Q. There was additionally no particular regard paid to occupation, such as teachers or police officers or, in fact, vaccinators. Again, do you think that it would have been possible to draw up a scheme for prioritisation that contained a significant nod towards occupation whilst keeping that scheme pragmatic, straightforward, relatively simple to operate?

DR KASSTAN-DABUSH: I think just to say that vaccinators who are healthcare workers would have been prioritised for vaccination.

Q. But because they were frontline healthcare workers, not because they were vaccinating?

DR KASSTAN-DABUSH: Absolutely.

Q. All right.

DR KASSTAN-DABUSH: So again, we have to remember the context at the time. There was a limited supply chain, particularly at the beginning, a reliance, for example on Pfizer vaccinations which were used in deployment following 8 December. So it really had to be guided by

the severity of risk and that guidance was indicating increased age. That's why they had to be the priority cohorts.

I think the issue of occupation, there might be lessons to learn from other jurisdictions that did do this, such as particular states in the US, that might inform future approaches, but I think what happened in Covid-19, again, this -- the context of supply at the time, the age-descending approach was entirely the most appropriate and responsible course of action.

LADY HALLETT: And if you introduce elements like occupation, what you lose is the simplicity that you said was so important.

DR KASSTAN-DABUSH: Well, how do you do that effectively and fairly? How do you distinguish the particular occupations that you will do and that you won't do? How is that going to look across the devolved nations? It's got to be fair and it's got to be consistent. And the easiest message to sell was age-ascending risk.

MR KEITH: My Lady, is that a convenient moment?

LADY HALLETT: Yes, certainly. I shall return at 3.20.

Sorry, I hope you were warned we take breaks.

(3.03 pm)

(A short break)

(3.20 pm)

LADY HALLETT: Mr Keith.
MR KEITH: Another topic arising in the context of the prioritisation list was that of unpaid carers, and Dr Kasstan-Dabush, at page 21 of the report -- if we could have that up on the screen, please -- you deal with the position in England, Northern Ireland, Scotland and Wales. And, in essence, the position appears to have been that unpaid carer status was not recorded in GP records in England, there was no register of carers in Northern Ireland, Scotland broadened its eligibility criteria for unpaid carers to those who'd received Carer's Allowance, Child Winter Heating Allowance or Young Carer's Allowance, and in Wales you refer to the fact that local authorities and GP surgeries were consulted on the information they held, but there doesn't appear to have been a single register.

Do you call for a system by which unpaid carers may be more easily identified, so that if, in future, there is a prioritisation of sole or main carers, for example, as there was here, unpaid carers may know who they are for the purposes of vaccine receipt, and not have to rely upon self-identification?

DR KASSTAN-DABUSH: Yeah. And this is a group of people who are responsible for some of the most vulnerable groups in society, those groups who would have been prioritised

quite highly in the list in phase I.

Obviously, one of the challenges is how do you identify that, and we can see that various -- you know, the UK nations took various approaches to doing that. Having some consistency could be very beneficial in order to do that efficiently, and make sure people get that offer when the time is right.

Q. Is it self-evident that you can't really have a sensible system of prioritisation that relies to a very large extent on self-identification?

DR KASSTAN-DABUSH: Well, self-identification -- I think there are concerns around self-identification because essentially it might open the door to some exploitation of receiving a vaccine as a priority person. It's certainly a helpful way, again, thinking about the variation, to have one common approach across the four nations, but ultimately, if we, you know, address this in a non-pandemic time, and have a system in place, we can then draw on that during a pandemic, whether -- you know, the question then is: what's the most appropriate place to do that? Is it at GP level? Is it at local authority level?

But having something may help.

Q. On page 22, you turn to the issue of disabled people. There was, in the prioritisation scheme, no general

category for mental or physical disability, was there?

DR KASSTAN-DABUSH: No.
Q. There was no general category for those who suffer from learning disability but there was a categorisation for those who have severe and profound learning disability, cohort 6, and I think those who have Down syndrome, cohort 4.
DR KASSTAN-DABUSH: Correct.
Q. Did the issue of prioritisation for those suffering from learning disability give rise also to definitional problems and difficulties with identifying who should receive an offer?
DR KASSTAN-DABUSH: And again, the consistency against the four nations of how do you identify that cohort for vaccination. For example, in England ultimately the Learning Disability Register was used as one resource, but obviously that is not in operation in the same way across all four nations. So that could be something to explore in the future, of, again, a UK-aligned approach to a disability register.

But ultimately -- I can see the benefits of that from an implementation perspective. Ultimately, I would say that DPO would be best placed to advise on the ethics and sensitivity and how to do that in the most appropriate manner.

Q. Frontline health and social careworkers, page 23. Frontline social careworkers were a priority group for vaccination in cohort 2?
DR KASSTAN-DABUSH: Yes.
Q. Obviously, careworkers in residential care homes were in cohort 1?
DR KASSTAN-DABUSH: Mm-hm.
Q. But there was no general priority for health and social care workers. Did England and Wales maintain a central register of social care workers which would enable those prioritised groups to be offered a vaccine?
DR KASSTAN-DABUSH: I mean, it -- no, the social care sector in England is incredibly fragmented, broken up across lots of different services and sectors, so again the ability to identify that cohort based on eligibility wasn't there.

I mean, the very fact that there were questions raised of who is responsible for giving me my vaccination as a social care worker, it's quite ludicrous in a pandemic that that question would come up. It's got to be very clear that if you're prioritised then, again, that system of who's responsible for giving and offering to you is very clear. But in assessing the evidence in this report, that was one of the issues that were raised in England.

We know in Scotland a different approach was taken of offering care home residents and their carers working there vaccination in the same opportunity, which, again, has real operational benefits for protecting two priority cohorts.

So I think there's lots of learning there on that approach that was taken.

Q. Children and young people. There was a -- quite a divisive policy debate as to whether or not they should be offered vaccination, and you deal in your report with how the JCVI gave its advice but then looked to the CMOs for the United Kingdom to provide advice on the educational and wider societal or, at least, wider benefits to children and young persons of being offered vaccines. And that put something of a delay into the process.

You then deal with the operationalisation of childhood vaccination at pages 26 and 27. And was one of the most profound differences, in terms of delivering vaccines to children and young persons, that in Scotland, the delivery plan was pursued by way of a combination of primarily community clinic-based, delivery points as well as school, whereas in England, as with routine immunisation of school-aged people, delivery was organised through I think a body called

SAIS, which you'll remind us, was --

DR KASSTAN-DABUSH: School Aged Immunisation Services.

Q. Thank you very much. And because that delivery process in England was tied to school, it gave rise to concerns about people having to go to school to get vaccinated, and also it meant that the English vaccination process for children and young persons started to lag behind that in Scotland? Have I summarised it fairly?

DR KASSTAN-DABUSH: I think that's a really fair summary.

Q. And so what views do you reach as to whether, in future, vaccination of children and young persons should be exclusively pursued through a school-based system?

DR KASSTAN-DABUSH: Well, let's call a spade a spade, delivering vaccines via schools are super efficient because you've got the population going there every day who are eligible for vaccinations, let's commission a provider to vaccinate them. The problem is there are issues around consent, efficient streamlined processes of getting parental consent in order to vaccinate on the day. There are schools that don't have that relationship with providers in order for them to get through the door and deliver on that offer.

Also, in a pandemic with a rapidly developed and implemented programme it's quite reasonable to expect that parents would want to be with their child as

they're getting this vaccine, and have the chance to ask questions, make sure that their children are okay post-vaccination. I think that's entirely reasonable.

So having a dual process, either taking your child to a GP surgery, which ultimately did happen in England, or via schools and having that flexibility and that choice, I think, is really crucial.

Q. So flexibility or a blended programme is the way forward, and in Northern Ireland, did officials there use both a school-based programme based on the influenza approach, but also led by trust/school nursing teams and supported by GPs, and in Wales was there a blended programme of vaccination centres and schools?

DR KASSTAN-DABUSH: To the best of my knowledge, yes.

Tracey, I don't know if you want to ...

Q. So England was the outlier until they brought GPs into the picture --

DR KASSTAN-DABUSH: (Witness nodded)

Q. -- and started vaccinating outside SAIS?

DR KASSTAN-DABUSH: But that's, again, very much based on the way that routine programmes are delivered to this cohort, which is via School Aged Immunisation Services, so it was probably that consistency. There were broader issues, of course, that we can raise around, you know, the language of a non-urgent offer for some of the child

cohorts, but is there anything on the ...

DR CHANTLER: Yeah, I just want to make the point that we're not necessarily advocating for school -- school-aged immunisations to have a blended approach, where it's up to the parent to choose whether they want it at school or at a GP. I think there is already in place in England, you know, the fallback of going to the GP, but primarily it is that children get their adolescent vaccinations for schools, and we need to emphasise that. But in this pandemic process, in this instance where it's a new vaccine and parents probably wanted more information, there should have -- could have been -- it could have been better delivered with that dual offer: both in GPs and schools.

Q. All right.

Dr Chantler, we're now going to look at the section of your report dealing with planning for deployment at capacity to vaccinate across England, Northern Ireland Scotland and Wales. That's the order in which you, in fact, approach it. And I just want to highlight some of the difficulties that were encountered by the vaccine-related bodies in planning for and arranging for delivery of vaccination.

In relation to England, paragraph 95 on page 30, you refer to the fact that healthcare record systems do not

routinely record membership of certain health inclusion groups.

By that reference, did you mean that the records kept by GPs do not routinely record health inclusion groups? That's paragraph 95 on page 30.

DR CHANTLER: Yes. We do. So, I mean, it wouldn't -- or, I mean, there are protected characteristics, so this would not necessarily always be included in GP records.

Q. All right. GP surgery contracts, you refer to the need to negotiate those contracts. And by and large, we haven't, in fact, got into detail in the course of the Inquiry of how those surgery contracts were negotiated. But do you say in paragraph 98 that in future it's going to be important to put into place a process by which "sleeping contracts", perhaps, can be put into place, that is to say broad outline arrangements made with GPs so that no time is spent or having to be spent in terms of negotiating contracts in the face of the next pandemic?

DR CHANTLER: Yeah, I agree, that is a point that we make strongly here.

To be fair, I think, you know, the commissioning of GP practices in the primary care networks was done very rapidly, so that did work quite effectively, but they were -- the primary care network provision was quite --

it factored in quite late. But I think there is a place for sleeping contracts, but we do have to be aware that the finer detail is going to be difficult to cover, because we don't know what the next pandemic is going to involve. So you have to think about the epidemiological characteristics and who are going to be our risk cohorts.

Q. All right.

DR KASSTAN-DABUSH: Can I quickly add to that? I mean, we know that this point was raised in the Hine review of the H1N1 pandemic. We don't know whether those recommendations were followed up and how. But again, we saw the consistency of how that came up in Covid.

Q. Then, in terms of delivery, Dr Chantler, on page 32 you address fairly speedily the main delivery routes in England. And just picking up some of the points that you make, at the end of paragraph 99b you say:

"This type of flexible provision should be included in preparedness plans to enable access to an expanded workforce."

And you refer there to the system in England by which healthcare assistants, under clinical supervision, and volunteer vaccinators, were able to deliver vaccines.

DR CHANTLER: So I think I've -- which paragraph?

Q. This is page 32, paragraph 99c, primary care networks. And then just above that, there is a paragraph under the heading "Mass vaccination sites". You say:

"This type of flexible provision ..."

DR CHANTLER: Okay, yes, sure.

Q. So it's the subject of vaccinators.

DR CHANTLER: Yeah. I mean, I think of the key thing to say about vaccinators, and in England there was the national protocol that was brought in, in order to train up an additional cadre of vaccinators who would be supervised by health professionals, and that proved to be really important, and in Scotland that was also done through health boards. And I think that does need to be included. But more importantly, we need to think, within our health system, who are the health professionals who could be supporting routine vaccination and then could be upskilled or kind of -- their training renewed in outbreaks and pandemics. So we're talking about the touchpoints, so the hospital clinics where people with diabetes or liver disease are seen, places, so making sure that health professionals that Immunisation training is part of a core requirement for frontline health professionals that have interaction with the risk groups and others requiring vaccination.

Q. The evidence before the Inquiry is that in part health

and social care workers and in part volunteers were trained to operate as vaccinators in the course of the pandemic response, and there's no evidence that it took too long a time or that that slowed down the delivery of vaccines, which started across on 8 December.

Were you aware, from your review, as to whether or not there had been a delay caused by the need to train vaccinators generally in the United Kingdom or do you think that system in general worked in practice quite well?

DR CHANTLER: It worked quite well, but I think it could work better if we built more consistent training for health professionals and also for those like health visitors and others to maintain that -- skills and to be able to use them rapidly in future pandemics.

Q. In the following paragraph you deal with primary care networks. Again, this is in England. And you say this towards the end of the paragraph:

"[Primary care networks] were able to make efficient use of vaccine supply, which is not replicable in [the devolved administrations] such as Scotland as GPs are organised by an 'individual practice model of delivery'."

In Scotland, there is in fact a health trust. Indeed, are health boards in Wales and, perhaps, a more

centralised system in Northern Ireland, but it doesn't appear as if primary care networks in England were faster, ultimately, in being able to divide up the pizza boxes of vaccines, and to be able to get through their supplies. Is there evidence, in fact, that you saw, to suggest that PCNs were more nimble than the GP system in Scotland for -- in terms of getting supplies?

DR CHANTLER: I couldn't say so, no.

Q. All right. Community pharmacies. We've heard considerable evidence about their existence and the National Pharmacy Association wrote to the UK Government extolling the virtues of community pharmacies and explaining how they could assist more. What view did you reach as to whether or not community pharmacies were sufficiently utilised?

DR CHANTLER: Community pharmacies came on later than the mass vaccination sites and the GP practices or the PCNs of the collection of GP practices, but they were an effective route of providing vaccines. I think they were initially hampered a little bit by some of the commissioning requirements for them to be able to deliver large amounts of vaccinations which they couldn't necessarily, on their kind of individual site, but then needed to kind of get larger sites. And there is evidence that shows that community pharmacies were

located in areas where there's higher levels of social deprivation so they could play a really important role in also providing walk-ins and closer services.

LADY HALLETT: Professor, can I just ask you a question in relation to that. In relation to that, I was concerned about that, and whether community pharmacies should have been used earlier on, but then we've heard an awful lot about the problems about storing and transporting Pfizer, and therefore, it wasn't practical to just have small pharmacies, and you may end up with a great deal of waste. So one has to factor that in, don't you, to the later involvement of community pharmacies to the extent that they did become involved?

DR CHANTLER: Yeah, I would agree, they had to set up and make sure all the logistics were in place and I think often they would do that, have a central provision and have certain days for certain vaccines and pre-booking that. But, I think, yeah, pharmacies were kind of -- had to also find other locations in order to provide -- be able to provide vaccines -- at that kind of higher level of vaccines to be given per week.

MR KEITH: Page 33, please, paragraph 103. In the context of dealing with the centralisation of which you spoke earlier, Dr Chantler, you refer to the fact that there was some concern expressed at local and regional level

that the degree of centralised control hindered the process by which specific strategies were designed and local and regional communication routes were utilised to be able to break down barriers and to encourage uptake.

Although those concerns appear to have been expressed, is it your assessment that certainly by the time that the major part of the priority 1 process was complete, a great deal of attention was actually being focused, in practice, upon developing, designing and using tailored community routes?

DR CHANTLER: Yeah, I think this goes back to what we were talking about. We had that table earlier with all the different people and you talked about the tree and people going up and down, there needed to become a point where people could -- actually those involved in the provision really voicing that their expertise and the insights that they have at regional and local level in order to be able to really steer the implementation, and not only steer it, have access to the funding that allowed the tailored provision of services, which came a little bit later. And we've touched on that already.

So that -- and this is where we do talk about and we reference some research that was done, that it was kind of after three or four months of the kind of start-up of the programme, that this gradually changed and you had

the local and regional areas really coming together, and I think in England, the key there is also that you started having vaccine inequality committees being formed at regional level. That included the DPHs, so the directors of public health, with the regional officers, the NHS England staff who were responsible for the implementation. So you brought people together who were sometimes fragmented otherwise.

Q. And is that why you say, on page 34 at paragraph 107, that what's important is establishing bodies to address specifically the issue of vaccine inequalities outside central government? So outside and below the DHSC, for example.

And would you endorse the creation of regional and community groups who have got the knowledge to be able to design tailored delivery processes and also know their local communities better than central government?

DR CHANTLER: I think what we really would like to see, moving forward, is the -- kind of the addressing what are the inequalities that vaccination programmes need to address, and having kind of national-level policies but having, at the local and regional level, groups of people that come together, both health professionals and community groups, representatives of underserved groups, including disabled groups, and thinking about what could

be done to improve and to tailor services.

I'm not saying that you then possibly need to go away with the health professionals to design that but then continuously getting input and I think that's what's going to be core, moving forward, is that kind of strategic community engagement at the -- yeah, appropriate level at each kind of local/regional/national level.

Ben, I don't know if you want to add anything there.

DR KASSTAN-DABUSH: No, I don't think so, other than, you know, what's very -- what's often not clear is the accountability that such groups have to measure progress and changes and upticks, and so I think that comes together with such groups.

Q. If they're delivering tailored delivery procedures and processes and they know their local communities and they're coming up with the goods, does accountability matter? I mean, is that not just a heightened unnecessary degree of administrative process?

DR KASSTAN-DABUSH: I don't know if I agree because I think it's really crucial to ensure that changes happen when they're needed, to learn from past limitations, shall we say, or failings, and create an agenda for change in partnership with those underserved groups.

Q. All right. Northern Ireland. You refer on page 36,

Dr Chantler, to the fact that the Department of Health established a Northern Ireland Covid-19 Vaccination Programme Oversight Board and that delivery was initially managed through trust-led mass vaccination sites and the GP surgery teams, and then the community pharmacies came on board.

Do you assess that there were a sufficient number of community and regional-based entities and people in the Northern Ireland system to be able to deliver necessarily tailored, specific delivery plans?

DR CHANTLER: I mean, this falls back to the "we don't have as much access to evaluations on the Northern Ireland devolved administration". One thing I do want to highlight with Northern Ireland is their very novel approach of a twin-track approach which you can see in paragraph 116(c), whereby different priority groups could either go to the trust or to the GP surgery at the same time, which was a really good way of offering at a fast pace and that was quite directive and clear to the different priority groups. So I think that was a really, some learning that could be taken forward.

Community pharmacies did come on later and then some of the issues, the limitations we've talked about, the complexities of delivering Pfizer and other vaccines, and I think it was probably in England where they played

a greater role than in other devolved administrations, but there's definitely scope and there's discussions even now ongoing for the routine programme of formalising the contribution of community pharmacies to a routine programme which I think will benefit future pandemic preparedness.

Q. You also highlight the fact that Northern Ireland was the first UK nation to deliver Pfizer vaccines in care homes via a trust mobile team.

Obviously, there were complexities, as you said, surrounding the Pfizer vaccine because of the need to keep it frozen, but it would appear that their mobile -- which is necessarily a highly tailored specific process of delivery -- got going very early on, and achieved a great deal within a relatively short space of time.

DR CHANTLER: Yes, agree.

Q. In Scotland, page 37, you note the National Vaccination Inclusive Steering Group, the blended approach to delivery, and of course, the fact that for winter 2021, there was an integrated flu and Covid vaccination programme.

DR CHANTLER: Mm.

Q. How did that integration of programmes assist in the speedy delivery to, in particular, marginalised communities?

DR CHANTLER: I think what we have to take into account with Scotland is that they were in the process of changing the provision of routine vaccinations from primary care, from GP-led primary care, to vaccination centres. So then the vaccination centres, the pragmatic combination of offering flu and Covid in that autumn made sense. I do not necessarily think that that on its own supported reaching out to marginalised communities, and I think there was a definite kind of -- that health professionals in Scotland would have liked to have been able to do a more tailored provision.

Q. Presumably, because there was a system of combined vaccination already up and running and the transformation was, to a significant extent, already done, and complete, there was a practical experience in the system already operating? I suppose that's what you would note?

DR CHANTLER: In parts of Scotland, but not in all parts, and I think some of the Scottish Health Boards, particularly in some of the more rural, dispersed areas were still running quite a lot of vaccinations through GP surgeries and through additional outreach.

Q. You refer, as it happens, to the fact that Public Health Scotland in 2020 had conducted a health inequalities impact assessment, this is page 38, paragraph 123. Do

you think that that process, that inquiry, or that review, assisted with the delivery of vaccines to --

DR CHANTLER: Yes.

Q. -- people suffering from inequalities?

DR CHANTLER: Yes, I think that would have definitely helped --

Q. And is that because it highlighted the issue? It really put it up in lights that there was an issue that had to be tackled? Is that how it worked?

DR CHANTLER: Well, it comes back to these things have to be spoken, documented, and then funding and resources needs to be allocated to actually address it. And I think this comes back to what we were talking about, the accountability and kind of recognising where the barriers are and then thinking about how do you address it. So ...

Q. On page 39 you deal with a different aspect of delivery in Scotland, which was the delivery of Pfizer vaccines into care homes in September 2020, and you note that Scotland initiate a policy of vaccinating care home staff on the same visit as residents.

Was that something that Scotland did differently, was that not in place for other countries, or -- or were they an outlier in that regard?

DR CHANTLER: They were an outlier, and -- as far as we're

aware. And I think this a key learning to take forward and to think about, and we touched on this already with the carers question earlier, to actually making sure that there's a clear offer and that carers know where they can be vaccinated.

Q. In Wales -- page 41, please -- a Wales Covid-19 Vaccination Board was developed, as we've heard in evidence during the course of today, and the Covid-19 vaccination board had representatives from the seven Welsh health boards on it, and those Welsh health boards had representation from public health directors.

DR CHANTLER: Mm-hm.

Q. Do you conclude that that process by which directors of public health were brought closer into the integrated approach to health assisted?

DR CHANTLER: It definitely assisted, I think, and was supported by the decentralisation and allowed, I think, Wales also to do very much a decentralisation approach. In England, and I was involved in one of the evaluations we reference, we found that when regions were developing their vaccine inequalities committees, that's when you got the DRPHs talking to the NHS England strategic officers or the -- you know, their area officers. So that had to be created, whereas this existed already. So I think again, this is key learning as we think

forward for, you know, vaccine equity committees or accountability groups across the system.

Q. And in Wales also, the health boards have a high degree of integration of primary and community health services and secondary and tertiary care, so they have perhaps a better understanding across the whole range and breadth of the healthcare services being provided in a particular region?

DR CHANTLER: Yeah. And I think this comes back to a word we do use in this report a lot, it's about this "place based", when you think about how to best provide immunisation services within a geographical area, knowing the population, understanding the social and healthcare services. So if you've already got a health board that has representation of all those groups and regularly talks, that's only going to be a bonus.

Q. And in Wales also, was there a Vaccine Equity Committee, of which we've heard something in evidence; this -- the presence or existence of a committee specifically dealing with equities is of value, is it not?

DR CHANTLER: Yes.

Q. And were there also -- I think there were also equity committees in Scotland and in Northern Ireland.

DR CHANTLER: Yes.

Q. But perhaps not a self-standing equity committee in

England. But you'll correct me if I'm wrong.

DR CHANTLER: I think there were vaccine equity committees, and particularly regional levels, and they were created over time, again with input from directors of public health.

Q. But perhaps less prominent than the --

DR CHANTLER: Yes.

Q. -- analogue from Wales and Scotland?

DR CHANTLER: But they will have come into Wales during the Covid pandemic, yes.

Q. Picking up the threads of your conclusions at pages 43 to 45, firstly, do you make the point that operational flexibility is vital in order to ensure that a prioritisation strategy is applied as fairly and as widely as can reasonably be made to work?

DR CHANTLER: Yeah, we would agree. And I think it's about that balance of pace but also providing equitable services.

Q. And in terms of the structures in place, the more that can be done to focus on bodies focusing on equities, or lack of equity, and the more that healthcare providers can have a proper understanding of their local or regional area by way of integrating care, health and possibly routine immunisation, the better, because it all adds to the general degree of knowledge and

experience?
DR CHANTLER: Yes, can only agree.
Q. All right. And then we turn, please, to -- in fact I should have actually asked you, Dr Kasstan-Dabush, is there anything on the conclusions that you want to add? This was an area that you were particularly focusing on.
DR KASSTAN-DABUSH: No, I think Tracey covered all the key points.
Q. All right.
You provide a number of charts and a fair amount of statistics demonstrating the level of coverage across all four nations. They are what they are, and we've heard a fair amount about the levels of take-up, so we're just going to highlight, please, Dr Chantler, how you've provided charts divided by sectoral area or age or geographical location.
Page 47, do you provide a chart showing people who received at least one dose of Covid-19 across each country?
DR CHANTLER: Yes, we do.
Just to note, is that this is based on the whole population and not necessarily the eligible population, this chart.
Q. So it's divided by the total population --
DR CHANTLER: Mm-hm.

Q. -- rather than, for example over-18s or over-12s or something like that?
DR CHANTLER: It's just that under-5s were not offered the vaccination, so there could be a slight bias in the figures.
Q. And it's only up to September 2021 and it's at least one vaccine dose rather than two --
DR CHANTLER: Yeah.
Q. -- or a third and a booster.
Page 49, you produce a chart showing percentage of adults receiving two vaccinations segregated by age. And as is absolutely obvious, self-evident, the more elderly in our population had a much higher take-up than the younger cohorts; correct?
DR CHANTLER: Correct.
Q. Page 51, there's a chart going showing under-vaccination, and, by and large, was there a greater proportion of under-vaccinated people in younger age groups, as might be expected?
DR CHANTLER: Yes.
Q. Then on page 52 there is a chart showing vaccination by age. I don't think we need to dwell on that. There's a chart on page 54, take-up by sex. And then on page 55 you turn to ethnicities.
And can we just look, please, at page 55 and

paragraph 179. The headline point is, and the tribunal has already received considerable evidence on this, in England:
"Ethnic minority groups ... had lower age-standardised rates of vaccination coverage compared with ... White British ... Covid-19 vaccine uptake varied by ethnicity in upper age priority cohorts ..."
But:
"Among adults aged 80+ who received two ... doses, people of Black African and Black Caribbean ethnicities ... had lower-levels of uptake compared to ... White British ..."
Then you go on and give details of take-up rates amongst black African people, and Indian ethnic groups. And over the page, how adults aged 50 and over who received two doses, adults of black Caribbean ethnicities were consistently the least vaccinated minority.
By June 2022, however, had people of black African ethnicities reached the 75% threshold that was used as the font for the planning assumptions which were applied, at least by the UK Government?
DR CHANTLER: So just to note here, we will be submitting a correction, because there was some additional data that was in a previous chart that's been removed.

So by June 2022 in England, 81.7% of black African adults aged over 50 had received two Covid vaccines. So yes, they reached that threshold of 75%. However, it was lower in black Caribbean groups of over-fifties. And it was lower in black African over 18 -- and over 18 years old(?).
I think also the point I just want to reiterate, and I know we've covered it already, is I think to us we were extremely concerned that the black Caribbean and black African people over-80 people had such a low uptake that didn't catch up as quickly as in other ethnicities, given that they were priority group 2, and I think this is a really important thing for us to take on as learning moving on. And I know you've covered that in other modules as well.
Q. Is this the point that the over 80-year-olds were, of course, most at risk --
DR CHANTLER: Mm.
Q. -- and therefore, if you have a significant proportion of over 80-year-olds in any particular ethnic minority group who aren't reaching the same level of take-up as other over 80-year-olds, there's a major public health concern there?
DR CHANTLER: Yeah, a major issue for mortality, morbidity, and the fact that these groups were not vaccinated was

more important than their underlying health conditions or issues. If this group had been vaccinated more rapidly, if the trust was there and they'd received the vaccines, we would have seen less morbidity and mortality in those groups.

Q. And there are other links, aren't there, as well, because other evidence before the Inquiry shows that a significant proportion of the workforce in care homes, for example, is drawn from the ethnic minorities and therefore reductions in take-up rate in ethnic minorities who happen to be in the care home workforce, can have an impact on levels of incidence and transmission in care homes?

DR CHANTLER: And I think it makes a strong case for actually, if we're really wanting to talk about community engagement, we know that a lot of our frontline health professionals are from black Caribbean and black African, including doctors, nurses, so actually getting their input also in the design, having higher level representation of those groups in, you know, design of programmes, delivery of programmes, messaging, I think would make a huge difference.

DR KASSTAN-DABUSH: Can I just interrupt just to go back to your question about does accountability matter. Clearly, when we look at that --

Q. That's obviously riling you, Dr Kasstan-Dabush.

DR KASSTAN-DABUSH: Sorry?

Q. That has obviously riled you, my question?

DR KASSTAN-DABUSH: It hasn't riled me, no, I think it's just an important question to address because it's quite clearly a life or death matter, it has to be said.

Q. All right, thank you very much.

You then provide figures from Public Health Scotland which published disaggregated data, the percentage uptake in Wales and also Northern Ireland. And broadly speaking, in all four nations, was uptake significantly lower in black African and black Caribbean ethnic minority groups?

DR CHANTLER: Yes.

Q. All right. Were you able to provide figures for uptake amongst the Roma, Gypsy, and Traveller communities in Scotland, and I think Wales?

DR CHANTLER: Yes.

Q. And also, data segregated by, defined by religion and socioeconomic status.

DR CHANTLER: So data and religion is a little bit more complicated due to protective -- (overspeaking) --

Q. We don't need to go there, I was skating over that, Dr Chantler.

DR CHANTLER: Yes, all right. We were able to touch on it.

Q. All right. Socioeconomic deprivation is perhaps of more importance. You point out that the difference between more and less deprived areas was sharper in England than any other nation in the United Kingdom, but that even in Scotland in the most deprived areas, there was a significant difference intake-up?

DR CHANTLER: Yes, I think it's fairly clear that there are, even though in Wales, I think it was only a 5% difference, but there are significant differences between least deprived and most deprived population areas.

Q. And you provide figures for health and social care worker take-up, figures for homeless people, those who have experienced substance misuse, prison population, and disability. Those figures are what they are, and of course it's one of the reasons why we're all here, is because there are disparities across almost every type of ethnic, socioeconomic, geographical divide?

DR CHANTLER: Mm.

Q. All right.

We can then move forward, please, to data.

Dr Kasstan-Dabush you look at, from page 70 onwards, the methods that were used to obtain data on the UK Covid-19 vaccine's coverage across the United Kingdom. It's obvious from the data that you've been able to

produce that there is a fairly high degree of understanding as to what the take-up rates were. But do you have concerns about the efficiency or the standard by which data is able to be gathered on this important topic?

DR KASSTAN-DABUSH: Yeah, I mean, the availability of data is because of the standing up of clear systems, or pivoting systems in the case of NIMS, National Immunisation Management System, from influenza to Covid-19 vaccination in England, whereas other devolved administrations had to set that up in realtime, and that gave insights, for example, by collecting numbers of vaccines administered by different sites, which is really, really crucial that -- the jargon, forgive me, is interoperability of a vaccine delivered in primary care and community pharmacies and outreach or vaccine centres can all go into a central place and integrate that data, that didn't necessarily exist before. So having these systems in place was extremely crucial.

And that allowed to have kind of ideas of coverage. There were limitations. For example, we didn't really always have a clear idea of uptake among particular underserved populations, those that aren't captured through those systems. So you'd need an NHS number, for example, for an invitation, for that data to --

Q. Just pausing you there, the systems for data gathering and the interoperability of those systems improved over time. Of course, in the face of the pandemic, great strides were made, but there were some specific areas where problems still remained.

DR KASSTAN-DABUSH: Yeah.

Q. We've discussed data, obviously, about unpaid carers, health and careworkers, those who suffered from -- or those who had disability learning issues, and was there also problems in relation to whether or not individual national systems recorded ethnicity at the point vaccination?

DR KASSTAN-DABUSH: Yeah, and which ethnic categories and codes are used and which are not, for example, limitations in Roma, Gypsy, Traveller or limitations in Jewish communities where we know that there was lower level uptake in the routine programme. So those -- and, of course, those who don't have secure immigration status who wouldn't have an NHS number to be kind of called up in the first place.

Q. So there were problems in relation to the Gypsy, Roma, Traveller community and also migrant of whatever type in relation to whom there wasn't a sufficiently well-developed data system.

DR KASSTAN-DABUSH: Mm-hm.

Q. This was of course a pandemic, we're concerned with the issue of vaccination, and it's obvious that there were -- a great deal of work was done in terms of extracting from health data systems information about patients. The OpenSAFELY system, I think, recorded and produced anonymised versions of data relating to tens of millions of patients. Is the general system for the assembly of data and the dissemination of data in the health system a good one? Does it work, in your view, relatively well, bearing in mind the complexity of the healthcare systems in this country?

DR KASSTAN-DABUSH: Well, you know, the limitation I think that we came up against was that UK-wide picture, you know, the alignment of data across the four nations, to be able to look at coverage in particular cohorts, age demographics, et cetera, and it's that alignment, I think, of how data is collected and stored that there could be significant room for improvement across the four nations.

Q. So the main problem appears to be that -- well, being able to join up the data from each of the four nations and be able to identify trends on a UK basis?

DR KASSTAN-DABUSH: Absolutely. Obviously there are clear questions because of the devolved organisation of healthcare but a huge asset if -- (overspeaking) --

Q. If it can be done.

DR KASSTAN-DABUSH: (Witness nodded).

Q. Now, causes of disparities, which is really the heart of your report. Dr Chantler, this is an area on which you're majoring.

Do you make the important point that barriers to access, issues concerning, for example, transport, distance, communication, language, disability access, digital exclusion, overlaps but is distinctly different from issues concerning inequalities, historical discrimination, and the sheer levels of distrust amongst certain communities in government vaccines and a desire to take up an offer of vaccination?

DR CHANTLER: Yes, completely agree, and I think that has to be recognised, and we -- addressing barriers, increasing access is key and very important, and still also needs to be done with the relevant underserved communities. However, there are foundational issues that will -- might need other trust-building exercises in that, as we've already seen, that some communities that have, you know, been recipients of structural discrimination, only to name Windrush or others, you know, in order for them to trust government, to trust a vaccination programme within a pandemic context, where it's very much seen as a government acting into people's private lives, you

need to really address some of those structural issues, and that needs to start with conversations that lead to action.

Q. Why does acknowledging that there is a problem or that there is a cause of distrust assist so much in reducing the levels of distrust?

DR CHANTLER: Well, it's like the elephant in the room. Unless you talk about it, you're not going to take any action. Acknowledgement in and of itself is not enough, okay. And I'm not necessarily saying -- no, I won't go there. But I think it's easier to address the former, right, to look at the barriers, to look at how increasing, and that is critical, but alongside that, you also need to recognise the fact that people feel excluded, that health outcomes are lower in black African and black Caribbean, maternal mortality, issues like that. Unless that is really addressed, and that we actually have a health service that, you know -- kind of health outcomes are more equal across different communities, how can we, kind of, create a trusting environment?

I think we just have to be -- and that's going to need resources and staff.

Ben, I don't know whether you want to add to this, because it's quite ...

Q. I'll come to that, I'll come to Dr Kasstan-Dabush's views in a moment.

Dr Chantler, this a highly complex field. Presumably issues of distrust and lack of trust in government and in vaccines and in delivery programmes is also connected to other deep-seated issues concerning misinformation and the reliability of information, in the hands of all these prospective patients. So it's a highly complex issue.

How important is it to recognise, and this is a point you make in your report, that for many people, they labour under the burden of a combination of factors: physical, lack of access, so barriers to access, as well as social and economic deprivation, marginalisation to by virtue of being an ethnic minority, and therefore there's a combination of impacts.

DR CHANTLER: Mm.

Q. Why does that matter? Why does recognising that they are subject to, your word, intersectionality, matter, in terms of trying to improve the position?

DR CHANTLER: So that we don't have this idea that it's just one bullet will correct an issue, that you actually still kind of look much closer to the issues at hand and don't come up with simplistic solutions.

Q. By and large, did each of the governments in the four nations and all of their local and regional related entities foresee that there would be very distinct problems in terms of addressing disparities, and also take a variety of steps to try to solve the problem?

DR CHANTLER: Mm.

Q. I mean, that seems self-evident.

DR CHANTLER: The inequalities that manifested were not -- unsurprising. They were known. These are groups that even in routine programmes are -- tend to be underserved. In the -- the actual disparities, when we did the comparison between the influenza uptake and Covid uptake in black African, black Caribbean, it was actually even higher in Covid. Again, a new vaccine, new issues. Then who are the voices actually providing confidence or giving that confidence to those groups?

So yes, I think it was recognised, but I think what has been lacking in a kind of period of austerity and a lack of funding of public health, is the ability to engage with communities to build those relationships with representative groups of underserved communities so that in this situation, you're not having to suddenly gather people together that do not already work in partnership, but can actually built on existing trusted relationships, which did -- were in place in some areas.

So in -- particularly with some of the Orthodox Jewish communities, where there is, you know, already good partnership working, there was -- it was easier to act quicker.

So if that was in place, I think, you know, it would be easier to act quicker to promote trust and to address these variety of issues.

Q. Given that each of the countries did, on any view, a fair amount at the very least to try to address disparities in coverage, and given that the actual level of uptake was, in reality, higher than the levels of prospective uptake that might have been envisaged when one asks everybody in the community how hesitant they are about taking a vaccine, is there a limit to what can actually be done? So, putting it another way, do you ever get to 100% vaccine uptake in every community? Is it possible?

DR CHANTLER: I mean, just quickly on that, no, but it's -- you don't ever reach the 100%. Usually it's like -- depending on the vaccine, more like a 95% threshold for WHO for childhood. However, I want to go back, because --

Q. Just bear with me a second. It is possible, therefore, to reach higher levels of uptake than were in fact then reached in the United Kingdom? To be clear about that.

DR CHANTLER: Yes, yes. And we did reach higher levels in certain population groups. I mean, the -- in white population groups we were up to 97%. I think what is really important is that we did not reach that threshold level in all marginalised communities. And also, yes, those are based on the two doses, but then, you know, for all eligible vaccines the numbers drop over time.

We cannot be complacent. We have to be continuously promoting uptake of vaccinations.

Q. So that's very clear. It is possible to get to higher rates in certain communities, and therefore it should be possible, and it needs to be made to be possible, in relation to all other communities, so that they can get the public health benefit?

DR CHANTLER: Yes.

Q. That's the position. All right.

DR CHANTLER: And it needs to be resourced, as well. So we're talking about a resource that's important to -- in order to do that.

Q. In your report you set out, with respect to England, Northern Ireland, Scotland, then Wales, the steps that were taken. We don't need to get into the minutiae of steps, but in relation to England, you refer from pages 89 and 90 onwards how the government published it's four quarterly reports. You refer to the use of

the Community Champion scheme, the use of faith groups, and locations, the use of videos and webinars and roundtables, and debates with organised groups.

Just pausing there, similarly in Northern Ireland you refer, on page 94, to the use of pop-up clinics, existing mobile health checks, mobile clinics, key relationships being nurtured, a vaccine uptake toolkit. In Scotland, tailored outreach delivery processes. I think in Scotland one of the major vaccine leaflets was published in 30 different languages, I seem to recall you saying somewhere.

And in Wales, you focus on the use of interpreters, the improvement of disabled access, the work done with the Vaccine Equity Committee.

So a great deal of things were done. Where do you believe more could have been done? Is it a question of general funding? General resourcing? Or is it a question of setting up specific bodies that in future can be used to deliver these more tailored forms of delivery? Where should we be focusing our attention?

DR CHANTLER: I think it's on continuing some of those areas(?), but also embedding evaluations. So coming back to a point that we talked about earlier is that these interventions that were funded -- not in the pandemic scenario, but not -- are usually not funded in

a routine scenario, can be evaluated. You can demonstrate where -- effectiveness and which will work better in certain communities or might be generalisable to others.

So that's really important that that becomes embedded and that we also embed community engagement, but do it in a sense -- in a way that is effective and isn't, you know, only a talking shop, but actually includes action.

But I think this is also a topic that Ben was coverage in terms of addressing disparities, so Ben may want to add to that.

DR KASSTAN-DABUSH: I think it is just having the routine programme in a state of readiness that can be pivoted in a public health emergency when that inevitably happens. I don't think we had that in Covid-19. It had to be built in realtime. The goal should be to have that strong, robust, resourced routine programme so that we can be pivoted.

Q. And so is that why one of your main conclusions is: you need to have this system up and running, well resourced and working effectively for routine immunisation, so that in the face of a population-level vaccination programme it can be speedily pivoted, to use your word?

DR KASSTAN-DABUSH: Mm.

Q. Well, that happily brings us to the recommendations that you make from page 105 onwards.

And, Dr Kasstan-Dabush, I think you were going to speak to these issues, but I'm just going to summarise them very briefly.

Important point that you make on page 105, paragraph 370, is that you've got to have a robust approach to routine vaccine programme delivery so that, as you say, it can be pivoted readily towards a pandemic. Is that amongst -- would you say that's probably or one of the most important recommendations that you make in your report?

DR KASSTAN-DABUSH: It's certainly a priority. It's a higher-level recommendation, certainly.

Q. Children.

LADY HALLETT: I'm sorry to interrupt, but I think, given the time -- and I want to be, obviously, fair to the Core Participants -- I think I'm going to have -- I mean, obviously I'll be reading this report in full, and I can -- I've already analysed a number of the recommendations, I think we'll have to leave it for me to analyse, with your assistance, the recommendations.

MR KEITH: Of course. Well, I know of course you'll be doing that.

Could I just in one further question just suggest

this to you: that your main recommendations and the areas which you suggest we should focus our attention are on that question of routine immunisation, having a routine programme, on data, the data systems to which you've referred, and the great importance in having, in each of the four nations, specific taskforces that can focus on vaccine equity and do a great deal of the heavy lifting in the face of the next pandemic?

DR KASSTAN-DABUSH: Certainly. I think those recommendations you've drawn up will help to address the issue of pace and equity.

Q. Are those the most important of the recommendations that you make, would you say?

DR KASSTAN-DABUSH: I think they're umbrella recommendations for all that comes in topic 5.

MR KEITH: Thank you.

LADY HALLETT: Thank you.

Mr Weatherby.

MR WEATHERBY: Mr Keith dealt with the point that I raised.

LADY HALLETT: Oh, thank you very much, Mr Weatherby.

Who is next? Mr Wagner, who is that way.

Questions from MR WAGNER

MR WAGNER: I can't be quite as quick, but I will be fairly quick.

I ask questions on behalf of Clinically Vulnerable

Families and I want to ask you about barriers including accessibility, availability, and convenience of vaccine services. You, in your report, I'm at paragraph 99, you say that mass vaccination sites were not always suitable, possibly not safe, for a number of vulnerable cohorts in the JCVI prioritisation list, including people in older age groups, clinically extremely vulnerable, and people who have learning -- physical or learning disabilities. And you also say at paragraph 250 that clinically vulnerable people were likely to have heightened concerns about attending mass vaccination centres due to the risk of transmission in places of higher footfall.

Just two questions arising from that. First, in your view -- this isn't focused on -- either of you or both of you -- in your view, what steps could and should have been taken to ensure the safe delivery of vaccines to clinically vulnerable people?

DR KASSTAN-DABUSH: I think it's the identification, crucially, to who is that vulnerable cohort and the triaging them to the locations that make most sense, ie, not a mass vaccination centre, a primary care or an outreach site, for example, with quieter hours or hours for reduced footfall, longer appointment times, depending on the needs of the various groups you've

mentioned, I would say identification and triage.

Q. Right. Is that because the smaller vaccination sites might have fewer people?

DR KASSTAN-DABUSH: Well, you have more flexibility on what you can do.

Q. And secondly, what steps could be taken to prepare for the next pandemic, and ensure that those problems aren't repeated?

DR CHANTLER: Well, this learning in and of itself could be incorporated in planning. So I think, you know, thinking back, the idea was to get everything up and running at pace and even though I think there was kind of care taken for social distancing, things got omitted and overlooked. But building in that learning and thinking about those that are going to be clinically vulnerable in that pandemic scenario, can access vaccinations in the most safe place for them.

Q. So it would be, at that point, about identification?

DR CHANTLER: Yeah.

Q. And triage?

DR CHANTLER: Yeah.

MR WAGNER: Thank you.

LADY HALLETT: Thank you, Mr Wagner.

Ms Beattie.

Ms Beattie is over there. Can you see her?

DR CHANTLER: Yes.

Questions from MS BEATTIE

MS BEATTIE: Thank you. I ask questions on behalf of Disabled People's Organisations.

In your report, you refer to the National Immunisation Management System known as NIMS, which you've already mentioned this afternoon. You tell us that Public Health England used NIMS to undertake near realtime monitoring of vaccine coverage, and in their evidence NHS England say that NIMS was used to support almost every aspect of the national vaccination programme. But in your report you also referred to limitations of monitoring systems, in particular of NIMS.

Turning to disabled people, overall data about disabled people is not available from NIMS. So my question is, do you agree that the lack of data about disabled people in NIMS was a significant limitation of the monitoring systems used in the Covid vaccination programme?

DR KASSTAN-DABUSH: And this is a heterogeneous cohort, of course, and an umbrella cohort, and there are groups who were higher risk and higher prioritisation than others. The question is, again, in the routine context: where should that information be stored, and stored in a way

that's aligned across the four nations, in a way that can be pivoted? The specifics of NIMS as a limitation, I don't feel able to comment on.

Q. Right, but if data about disabled people is not being recorded, is that a limitation which prevents monitoring efforts from being accurate, and the picture of uptake, for example, by a particular cohort being comprehensive and therefore not giving necessarily the full picture to those who are monitoring the vaccination programme?

DR KASSTAN-DABUSH: You're right, and the urgency and the need for identification, absolutely.

Q. Just to follow that up, I think is one of your recommendations that it is important to be able to accurately disaggregate data according to protected characteristics, such as disability status?

DR KASSTAN-DABUSH: Absolutely. In order to be able to offer that tailored approach for those who need it. Absolutely.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Beattie.

Those are all the questions we have for you. Thank you very much indeed for your help preparing your report. As I said earlier, I promise I will make sure that all the material you put into your report is carefully considered. I'm really grateful to you for

the work you did preparing that and, of course, your colleagues who help you, and thank you very much for your help today.

DR CHANTLER: Thank you.

DR KASSTAN-DABUSH: Thank you.

(The witnesses withdrew)

LADY HALLETT: Very well. 10.00 tomorrow, please.

(4.28 pm)

(the hearing adjourned until 10.00 am the following day)

I N D E X