

Tuesday, 28 January 2025

1
2 (10.00 am)
3 **LADY HALLETT:** Mr Keith.
4 **MR KEITH:** Good morning, my Lady. The first witness today
5 is Derek Grieve.
6 **MR DEREK GRIEVE (sworn)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4**
8 **MR KEITH:** Could you commence your evidence, please, by
9 giving us your full name.
10 **A.** Yeah, my name is Derek Grieve.
11 **Q.** Thank you very much, Mr Grieve. Thank you for attending
12 today and also for the provision of your witness
13 statement dated 4 October 2024.
14 I'd like to start, please, by asking you some
15 questions about the Health Protection Division in the
16 Scottish Government. You became head of that division
17 on, I think, temporary promotion to a senior civil
18 servant on 1 May 2019. Did your position then become
19 permanent in August 2021?
20 **A.** It did.
21 **Q.** And what is the Health Protection Division concerned
22 with, in general terms?
23 **A.** So it covers a range of policies. That includes
24 screening, vaccination, some other activities such as
25 burial and cremations, and a range of other policy areas

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1 **Q.** So he was concerned with population health?
2 **A.** That's correct.
3 **Q.** And presumably your division, Health Protection, was
4 just one of the divisions for which he was then
5 responsible?
6 **A.** That's correct.
7 **Q.** Presumably then you worked very closely with ministers
8 in the Scottish Government?
9 **A.** I did indeed.
10 **Q.** From the First Minister, Nicola Sturgeon, to the Cabinet
11 Secretary for Health and Sport, Jeane Freeman MSP,
12 Humza Yousaf MSP -- I think he was Cabinet Secretary for
13 Health and Social Care after Jeane Freeman?
14 **A.** That's right.
15 **Q.** And also the ministers for public health as well?
16 **A.** Yes, that's right.
17 **Q.** Then did there come a time when you were asked to
18 establish and lead a Covid-19 vaccines policy division?
19 **A.** I was indeed. That was in June 2020.
20 **Q.** And who asked you to do that?
21 **A.** It was my director, Richard Foggo. He was also joined
22 by another director within government, Donna Bell.
23 **Q.** And it's obvious, you were asked to do that as part of
24 the Scottish Government's preparations for the
25 prospective vaccination rollout?

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1 that relate to health protection itself.
2 **Q.** It is plainly concerned with public health and, in
3 particular, the protection disease; is that right?
4 **A.** Yes, that's correct.
5 **Q.** How does it work with Public Health Scotland?
6 **A.** So Public Health Scotland weren't in existence when
7 I took that division -- when I headed that division, but
8 there's a very close relationship between government and
9 the clinical leads that -- of individuals that became
10 Public Health Scotland, so I had regular contact with
11 clinical leads and the organisational leads themselves.
12 **Q.** When you say "clinical leads", do you mean the
13 clinicians inside what became Public Health Scotland as
14 well as chief pharmaceutical officers, chief medical
15 officers?
16 **A.** Within government, yes.
17 **Q.** Within government.
18 Between January to June 2020, did you have policy
19 responsibility for the initial response to the emerging
20 pandemic?
21 **A.** I did indeed.
22 **Q.** Who did you report to?
23 **A.** So my director was Richard Foggo, the Director for
24 Population Health, of which my division sat within his
25 directorate.

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1 **A.** That's correct.
2 **Q.** Essentially, you were the Senior Responsible Officer?
3 **A.** That's right.
4 **Q.** Is that a formal position or is that a more informal
5 recognition of the importance of your role in the
6 vaccination programme?
7 **A.** It's more the latter.
8 **Q.** As Senior Responsible Officer, did you remain
9 accountable to other officials in the Scottish
10 Government, and ultimately to ministers?
11 **A.** Yes, I viewed my role as an SRO as an extension of being
12 able to provide ministers with assurance that the
13 policies were being operationalised and delivered.
14 **Q.** And then eventually, did all the vaccination-related
15 policy, was it all brought within a single directorate,
16 I think later in February 2021?
17 **A.** That's correct.
18 **Q.** Within your functions and responsibilities, were you
19 concerned with the setting up of a programme, the
20 programme for vaccination, of both Covid and influenza?
21 **A.** Yes, we took a decision to include flu during 2020
22 because we were concerned collectively -- and that
23 includes ministers -- of the impact of whether there --
24 if there was a bad seasonal -- flu season in late 2020
25 to coincide with an increase in Covid cases.

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

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

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

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1 The transformation programme I think you're referring to
 2 was the Vaccination Transformation Programme that hadn't
 3 been fully implemented at the start of the pandemic but
 4 the approach we took through the flu vaccination and
 5 Covid vaccination programme was predicated on that, the
 6 models underpinned by the Vaccination Transformation
 7 Programme.
 8 Q. And what, in essence, was the transformation process?
 9 What did it do, in practical terms?
 10 A. So the vaccination -- I'll use the acronym, the VTP was
 11 designed to modernise vaccination so that included, for
 12 example, developing new IT systems, having a new
 13 tracking system and call up system for all individuals
 14 for all immunisation activity, and importantly, removing
 15 vaccinations from GPs and that was part of the, I think,
 16 2018 GP contract that was agreed, so that, at its heart,
 17 it was designed to do that.
 18 Q. All right.
 19 Mr Grieve, will you just slow down a little bit,
 20 we're going quite fast.
 21 A. Apologies.
 22 Q. No fault at all, but if you just go a bit slower, it's
 23 easier for the stenographer.
 24 And then if we can just scroll out and look down
 25 further towards the bottom of the page, we can see there

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

9 **A.** Yeah.

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

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

16 **A.** Yeah.

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

20 **A.** Yes.

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

23 **MR KEITH:** Yes.

24 **LADY HALLETT:** You are going back to that?

25 **MR KEITH:** We'll come on to the structure in a moment. Yes,
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1 pharmacists or GPs -- extensively, because some of the
2 constraints with the vaccine, how it was delivered, they
3 came in large trays, they had a huge amount of
4 complexity around handling and transfer, and in Scotland
5 we didn't have GP surgeries that had the breadth of
6 coverage that we felt confident could use the vaccines
7 without high level of wastage.

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

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

21 **A.** Pretty much. So it varied, but the structure in
22 Scotland has something called integrated joint boards,
23 which is overseen both by the health board and the local
24 authority. So some health boards devolved
25 responsibility through these integrated joint boards,
11

1 indeed.

2 **LADY HALLETT:** Thank you.

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

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

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

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

25 In short, we didn't use primary care -- be it
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1 but ultimately the health board retained overall
2 oversight of the activity in their area.

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

5 **A.** Exactly.

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

12 **A.** Exactly right.

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

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

24 **Q.** Many of these issues are reflected in a policy document
25 which I want you, please, to look at and identify for
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1 us. We're not quite sure of its etymology.
2 INQ000499465.
3 Mr Grieve, this is a document which talks about
4 deployment of Covid-19 vaccines to care homes, and it
5 talks about the position in England and over the page,
6 on page 2, in Scotland, and it says under the heading
7 "Assessment":

8 "In Scotland, we are not calling forward over ...
9 80 year olds for vaccination in this first phase, with
10 the exception of those who are care home residents or
11 long stay inpatients."

12 And there's a reference to 950 primary care sites as
13 having been set up and then references to why you've
14 adopted the approach you did and also, the impact on GPs
15 in England, and you draw a contrast -- or somebody draws
16 a contrast with the position in England.

17 We assess that this must be a document dated around
18 mid-December because it talks about the imminent rollout
19 of vaccines through GPs in England and that started on
20 15 December. Do you recognise this document?

21 **A.** I actually don't. I recognise the content of it but, as
22 you've alluded to, I'm not sure who it's from or who the
23 recommendation is being made to, if it's programme or
24 ministers, but I do recognise the content of it.

25 **Q.** Is what it says about the number of reasons for the

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1 programme starting. So we had to be relatively measured
2 in our plans, and pragmatic, recognising that, for many
3 of these over 80-year-olds, we'd need to give them time
4 to make arrangements, many would have to be supported to
5 come to get vaccinated, and that took a bit of time.

6 And equally, because we didn't have the supply -- sorry,
7 I'm maybe speaking a bit fast so I will slow down.

8 **Q.** Slow down, Mr Grieve.

9 **A.** So the -- that allowed us a bit of time to ensure that
10 our deployment plans aligned with our expectations on
11 supply.

12 **Q.** The expert evidence commissioned by the Inquiry from
13 Dr Kasstan-Dabush and Dr Chantler, states that, by
14 comparison to the rest of the United Kingdom, you
15 delivered the Pfizer vaccine, in particular, quicker
16 into care homes than any other part, and that you had
17 a policy of vaccinating care home staff on the same
18 visit as you vaccinated the residents.

19 **A.** That's correct.

20 **Q.** So you got the numbers in care homes up very high very
21 quickly, relatively speaking?

22 **A.** Yes, we did, but that wasn't the objective. The reason
23 we managed to do that was because the Chief
24 Pharmaceutical Officer had found an exemption within the
25 Medicines Act that allowed us to pack down or break down

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1 approach that was adopted in Scotland correct? So there
2 were difficulties with packing down and supplying
3 vaccines to GP practices, that there wasn't a primary
4 care network equivalent arrangement in Scotland as there
5 is in England, and none of the GP practices in Scotland
6 had the ability to use the whole -- I'm going to say
7 pizza box -- the whole 975 doses within the very limited
8 amount of time that the Pfizer vaccine in particular had
9 to be used within?

10 **A.** That's correct, and that's what I was referring to about
11 the wastage.

12 **LADY HALLETT:** What does "pack down" mean in that context?

13 **MR KEITH:** Divide.

14 **LADY HALLETT:** Thank you.

15 **MR KEITH:** My Lady, that's not my word.

16 You, importantly, say -- or somebody says:

17 "There are more over 80 year olds than we have
18 vaccine for and so if we were to call this group forward
19 we would raise expectations that we then cannot
20 meet ..."

21 **A.** I think as we alluded to, at the very start of the
22 programme the supply was limited and we didn't have
23 a high level of confidence that we'd ramp up very
24 quickly, and therefore we literally couldn't have
25 vaccinated all the 80-year-olds on the first day of the

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1 these pizza boxes, as you've alluded to, under
2 supervision of an NHS pharmacist. But because of the
3 licence restrictions on Pfizer, the vaccine had to be
4 administered by an NHS employee, and that's why we
5 couldn't use care home nurses, but it did allow us to
6 take the vaccine to care homes.

7 But it was a very pragmatic decision if we were --
8 given we knew the care home workers were part of the
9 priority group, if you're in the care home and have the
10 vaccine there anyway, in order to, one, use that vaccine
11 and ensure there's minimum wastage, it made sense to
12 offer the vaccine at the same time to staff as well as
13 residents.

14 **Q.** Was that not happening in England? Do you know?

15 **A.** I honestly can't comment on what was happening in
16 England.

17 **Q.** All right. And then, in a general sense, when Delta
18 became the dominant strain of SARS-CoV-2, were there
19 changes in the rollout approach? Presumably by that
20 time, of course, you'd worked your way through the
21 priority list and everybody who was on that priority
22 list had at least been offered a vaccine?

23 **A.** I mean, to be perfectly candid, there -- I can't recall
24 a time there wasn't changes to the programme. The
25 evidence and advice from JCVI and MHRA required the

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

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

7 **A.** Yeah.

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

9 **A.** Exactly.

10 **Q.** And give us some idea, please, Mr Grieve of the degree
 11 of scale-up between mid-December 2020 and February/March
 12 2021, by which time it was expected that the vast
 13 majority of the priority recipients would be offered
 14 a vaccine.

15 **A.** Yes.

16 **Q.** And indeed, you met that plan.

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

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

9 **Q.** In what state were the relevant data systems?

10 Presumably there was an obligation to record, in health
 11 board records, the fact of each individual vaccination
 12 within a certain amount of time. Was it 24 hours?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 A. I wasn't an observer but we were briefed by BEIS but
2 there was not a governance role in that capacity.
3 Q. In your statement you refer to the quirk that the VTF's
4 governance system by which the VTF formally reports to
5 the UK Secretary of State for Health and Social Care,
6 had fallen behind the reality of the position which is
7 that post-devolution, public health was a matter for
8 Scotland, Wales and Northern Ireland, and the VTF wasn't
9 reporting formally, or in any sense at all, to Scottish,
10 Welsh, Northern Irish public health ministers.

11 A. I think that related more to the JCVI rather than to the
12 VTF. So the JCVI has been in place for a considerable
13 amount of time but you're right: the governance of the
14 JCVI has not been updated to reflect a post-devolved
15 settlement, so the JCVI formally reports to the
16 Secretary of State for the Department of Health and
17 Social Care, and then it is incumbent upon the
18 Department of Health and Social Care to inform other
19 health ministers.

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

25

1 come on to.

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

8 You always had that opportunity?

9 A. Yes, in theory, although the observers and the members
10 of the JCVI from Scotland were often clinical leads and
11 not --

12 Q. Policy or --

13 A. Indeed. And maybe didn't have that wider, broader
14 prospective of delivery.

15 Q. So perhaps the question of who attends and who observes
16 at JCVI meetings on the part of devolved administrations
17 is something that needs to be looked at?

18 A. Perhaps, as -- or indeed the governance of the JCVI to
19 reflect a post-devolved settlement.

20 Q. All right. You've already said that you worked very
21 closely with your fellow Senior Responsible Officers.

22 A. Yes.

23 Q. There already was, I think, a very high degree of
24 openness and candour, as we'll see in a moment from some
25 of the WhatsApps. That system, that relationship,

27

1 of how it should be delivered, is not undertaken in
2 a way that that has four-nation sign on and there were
3 times, as I think I alluded to in my statement, where
4 there appeared to be a misunderstanding of the way in
5 which health is delivered in a devolved setting.

6 Q. You're absolutely right, of course, I confused myself
7 because the VTF reported to the Secretary of State for
8 BEIS and it was within BEIS that the VTF was
9 a departmental body. The JCVI was a statutory body
10 reporting to the Secretary of State for Health.

11 Did it matter, in practical terms, that there was
12 this absence of governance reporting from the JCVI to
13 the Minister of Health in Scotland?

14 A. It's difficult to say, but there were occasions where
15 there was a suspicion that the JCVI, despite having
16 a member and observers, didn't completely understand
17 some of the subtle nuances in Scotland. So whether that
18 be, for example, Scotland has a different academic year
19 and schoolchildren go back to school in the middle of
20 August in Scotland, and it's slightly later in other
21 parts of the UK. It wasn't immediately clear that the
22 JCVI understood that and therefore -- and there were
23 some other examples, but there were times where we
24 weren't sure the JCVI understood the complexity.

25 Carers may be another example that you may wish to

26

1 appears to have worked extremely well; would you agree?

2 A. I would indeed.

3 Q. And did that process allow for almost every aspect of
4 the vaccination programme in the United Kingdom to be
5 debated, from statistics to rollout, the issue of dosing
6 interval, mixing vaccines, availability of stock,
7 prioritisation, wastage, particular sectors wanting
8 priority vaccination, workforce matters, everything?

9 A. Yes. Although we each, I'm sure, had a great team we
10 were working with in our own nations, there was a bit of
11 a kindred spirit and it was good to be able to -- at
12 times offload but also check how others were dealing
13 with some of the same issues.

14 Q. Presumably there was always going to be times when
15 documents were produced by the United Kingdom Government
16 and not enough time was afforded to the devolved
17 administrations to comment on them, and also when
18 politicians said things in the public domain which
19 perhaps required correction subsequently, or there were
20 unattributed comments or observations from unknown
21 sources in Westminster which caused horses to shy and
22 certain fluttering of feathers.

23 A. Yes, there were. And in particular I seem to recall in
24 January 2021 there was a series of those tensions. And
25 that was a time where confidence -- it was really

28

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

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

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

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

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

29

1 **A.** That's correct.

2 **Q.** All right. But the position was corrected?

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

6 **Q.** All right.

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

10 INQ000498602.

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

13 **A.** That's correct.

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

22 **A.** That's correct.

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

31

1 you've alluded to England using primary care networks.

2 We didn't. So there were subtle differences that we all
3 had to ensure were carefully understood by each bit of
4 the programme across the nations but also was embedded
5 in our communications.

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

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

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

16 **A.** It wasn't just unattributed, there was some -- I think
17 there was some attributed comments. But -- but yes.

18 And I think if recall correctly, the number that was
19 being quoted in the media was the number of vaccines
20 that were allocated to Scotland, not delivered. And
21 it's quite difficult to provide a vaccine to someone in
22 Wick when the vaccine is sitting in a warehouse outside
23 Liverpool.

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

30

1 vaccine strategy?

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

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

14 **A.** In essence, yes.

15 **Q.** All right.

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

18 INQ000477804.

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

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

32

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

33

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

35

1 **Q.** Page 11. On 4 January 2021, there is some communication
 2 concerning communications and the issue of
 3 communications.
 4 So page 11. Thank you very much.
 5 4 January at 20.49, Gillian Richardson, on behalf of
 6 Wales says:
 7 "No one is handling Comms to 3 non English nations.
 8 Ministers furious."
 9 What do you understand that to be a reference to?
 10 Was there an issue with the way in which, as you say, on
 11 a communication level and a public level, communications
 12 being made on behalf of all the nations were correct?
 13 **A.** Yeah, I seem to recall, and I think there's an earlier
 14 message in this chain where I asked Emily, at 19.58, if
 15 the PM was about to announce the timeline for
 16 completion, and I recall the Prime Minister did make an
 17 announcement at 8 o'clock that evening about England's
 18 timeline for completing priority groups 1 to 4. We
 19 didn't know that announcement was going to -- or
 20 I didn't know that announcement was going to happen, and
 21 I don't think any of the other SROs did and as soon as
 22 that announcement was made, understandably, all parts of
 23 our respective systems were asking us: "Can you match
 24 that timeline?"
 25 And we had predicated our deployment plans on the

34

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

36

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

4 Well, there's a little political dig in there, but
5 putting that aside, was this issue, from the position of
6 the devolved administrations, of them being unable to
7 put data into the public domain resolved? Did they
8 continue to be unable to put it into the public domain
9 or did you put into place a system whereby weekly or
10 monthly you could put the figures up?
11 **A.** Yeah. So it was resolved and we did put supply
12 information up on the Scottish Government Covid website.
13 I think, just to say, the programme and Scottish
14 ministers were really keen that we provided as much
15 information to the public, Parliament, and the press.
16 So we published a series of deployment plans to help
17 explain to the public and others what the programme was
18 doing and while it was doing it, particularly -- and
19 that was particularly important because we were asking
20 quite a lot of people to wait their turn, and we needed
21 the public to understand why we were taking the approach
22 we were taking, and having some of these figures that we
23 weren't able to rebut was putting that at risk.
24 **Q.** Now, Mr Grieve, we can look, I think, at some of the
25 more specific, practical aspects of the vaccination

37

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

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

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

13 **A.** That's correct.

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

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

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

39

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

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

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

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

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

15 **A.** That's correct.

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

19 **A.** Exactly right.

20 **Q.** All right.

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

25 Page 3, the third paragraph, we can see there that
38

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

4 **A.** That's correct.

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

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

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

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

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

40

1 and Sport.
 2 INQ000376371.
 3 Did this come from you, Mr Grieve? Do you recall?
 4 **A.** It didn't come from me. I think it came from the unpaid
 5 carers policy team.
 6 **Q.** All right. Within your division or within the Health
 7 Protection Division?
 8 **A.** It came from another bit of the Health family, but
 9 I would have seen and I would have been part of the
 10 sign-off of this advice before it went up.
 11 **Q.** All right. Paragraph 6 states that:
 12 "Official statistics indicate that around 690,000
 13 unpaid carers in Scotland ... [although that may be]
 14 likely an underestimate."
 15 So there was a significant problem -- or at least
 16 the terminological debate or definitional debate about
 17 who was an unpaid carer had the potential to be of
 18 enormous impact, given the sheer size of the cohort.
 19 **A.** Yes, but it's important to say that there was a piece of
 20 legislation in Scotland, the Carers (Scotland) Act,
 21 which set out the definition of a carer in Scotland,
 22 which I don't think was the same elsewhere in the UK.
 23 **Q.** Indeed. And if we go over the page to page 2,
 24 paragraph 10, the problem lay therefore not in the
 25 absence of that statutory structure, but that there was

41

1 our expectations.
 2 **Q.** Do you assess that the system you put into place did
 3 allow effective offering of vaccinations to unpaid
 4 carers in the way that you had obviously wished?
 5 **A.** Yes, I do.
 6 **Q.** Scotland has a number of rural communities, that's
 7 obvious and self-evident. How did you alter the system
 8 of delivery on the ground to ensure that those rural and
 9 particularly Highland and island communities were
 10 properly served?
 11 **A.** So, as I alluded to, we devolved responsibility to each
 12 health board, but we gave the -- the central team gave
 13 each health board quite a lot of support. So when
 14 Highlands, for example, and the islands, were developing
 15 their deployment plans and explaining to the programme
 16 where they were having vaccination clinics, how they
 17 were supporting people to get to vaccination, these were
 18 scrutinised and sometimes challenged, and changed. But
 19 we also, particularly in the Highlands, used far greater
 20 role of outreach activity. So vaccination teams going
 21 to rural and remote areas. And to that end, we did
 22 something called bundling, which might sound a bit
 23 technical but in essence we gave authority for the
 24 health board to not stick rigidly to the prioritisation
 25 group when it made operational sense to go to

43

1 no single register of unpaid carers and local data was
 2 patchy.
 3 **A.** That's correct.
 4 **Q.** All right. And presumably, there's a difficulty with
 5 people attempting to self-identify, because, whilst that
 6 might be absolutely fine in practice, it doesn't allow
 7 the government to be able to understand in advance how
 8 many people are likely to self-identify?
 9 **A.** Yes. So there were some unpaid carers who were in
 10 receipt of benefits, and we used that data to identify
 11 and target them for invitation. But you're right, for
 12 those that were not in receipt of disability benefit or
 13 benefits, then there was no way for us to immediately
 14 identify them and therefore we moved to
 15 a self-identification model.
 16 We did put in a couple of controls, though. So we
 17 used -- in the national -- in the vaccine helpline we
 18 adapted the script that when somebody phoned up and
 19 self-declared, to seek assurance that they were actually
 20 an unpaid carer. And likewise, if somebody was booking
 21 an appointment on the system, we asked them a series of
 22 questions to try to filter out -- we -- of course there
 23 was always a risk that somebody may be playing the
 24 system. Generally speaking, though, we -- the level of
 25 unpaid carers we administered was broadly in line with

42

1 a community and just vaccinate, for example, a whole
 2 village or an area, because that reduced the risk of
 3 vaccine wastage.
 4 **Q.** Was the health board or health boards responsible for,
 5 in particular, the Highlands and islands, able to roll
 6 out that more particularised, more tailored form of the
 7 delivery from the start of the vaccination programme or
 8 did it not really get going until later?
 9 **A.** So the role of bundling and outreach was -- tended to be
 10 deployed as we came down the cohorts a little bit,
 11 but -- bearing in mind the very start of the programme
 12 was directed at care homes and health and social care
 13 workers. It would be unfair for me to say we got that
 14 bit perfectly right. There was challenges. There was
 15 absolutely challenges with all of that. And as well as
 16 rurality, of course, there was inclement weather, and we
 17 were vaccinating over winter, early 2021, and that had
 18 an impact on people's ability to travel to vaccinations.
 19 And that's not just people receiving the vaccine but
 20 also the workforce.
 21 **Q.** Would it be fair to say that in relation to some of the
 22 younger age groups, age cohorts, for example, the
 23 over-seventies and the over-sixties, and in relation to
 24 the clinically extremely vulnerable or, you would say,
 25 high clinical risk, in the Highlands and islands, offers

44

1 of vaccination and delivery of vaccinations didn't
 2 proceed at the same pace as they did in the more urban
 3 areas?
 4 **A.** So it's a more difficult job in rural areas, by the very
 5 definition, because -- but there was the same level of
 6 support of outreach.
 7 I should also mention each health board used
 8 third sector organisations to both pick up the
 9 individuals at home and take them to and back for the
 10 vaccination. But of course, within rural areas, that's
 11 a more difficult job, and you can -- by its very nature,
 12 in an urban area you can support more people to get to
 13 clinics than you can do in a rural area.
 14 **Q.** Did there come a time in May 2021 where you recommended
 15 the approval of funding for the Scottish Ambulance
 16 Service to assist in the rollout, particularly for more
 17 rural areas, so they could get out to particular houses,
 18 to the housebound --
 19 **A.** Yeah.
 20 **Q.** -- and also to those who were unable to travel or who
 21 feared the risk of infection by travelling to
 22 vaccination sites?
 23 **A.** Yeah, we did indeed.
 24 **Q.** How big a contribution did that Scottish Ambulance
 25 Service facility make?

45

1 a community-based approach.
 2 And I think as I also said in my statement, it also
 3 allowed us to develop, for example, child-friendly
 4 vaccination clinics based on conversations we'd had with
 5 the Gold Coast in Australia, who were already
 6 vaccinating children.
 7 It was a bit of a risk, I'll be fair. We didn't
 8 know if it was going to work. But to be fair to the
 9 programme and indeed to ministers, they agreed to take
 10 that risk, and I think in the end it demonstrated that
 11 we had quite high and good uptake of vaccination for
 12 children.
 13 **Q.** You had a higher uptake of vaccines amongst 12 to
 14 15-year-olds in Scotland than, I think, was achieved in
 15 England; is that right?
 16 **A.** Initially. I think everybody broadly caught up with
 17 each other but certainly there was a point where
 18 Scotland was slightly ahead of the league table.
 19 **Q.** And what do you mean by the -- in the context of
 20 vaccination of 12 to 15-year-olds, "community-based
 21 approach"? A community-based approach, what does that
 22 mean in practice? Does that mean mobile units,
 23 community hubs, or attending local vaccination sites
 24 under the health board?
 25 **A.** It's the latter. It's a local, often a local

47

1 **A.** That was hugely beneficial. And as you alluded to at
 2 the beginning of the programme, it helped us to target
 3 the most vulnerable, but as we came down the age cohorts
 4 it also allowed us to deploy outside football matches
 5 and shopping centres and areas where the younger
 6 population are more likely to go, and take the vaccine
 7 to them rather than ask them to come to the vaccine.
 8 **Q.** In relation to the vaccination of 12 to 15-year-olds,
 9 the Inquiry is aware that, in England, vaccination of
 10 children was generally, although perhaps not
 11 exclusively, but to a very large extent, carried out by
 12 SAIS, the school immunisation service.
 13 **A.** Mm.
 14 **Q.** In Scotland you did it differently, did you not?
 15 **A.** We did.
 16 **Q.** And how did differ in general terms?
 17 **A.** So it's fair to say that, up until that point, we had
 18 delivered, for example, the child flu vaccine through
 19 schools. We had done that. But the programme took the
 20 view that if we had done that with the Covid vaccine
 21 there wouldn't be the opportunity for parents and
 22 guardians to have that informed consent discussions if
 23 they had any concerns about the safety of the vaccine,
 24 given the advice from JCVI was nuanced and more
 25 balanced. So we felt it was important to offer

46

1 vaccination site, which was often adapted to make it
 2 more child friendly, so there was space to have those
 3 conversations with parents and guardians, and decor and
 4 the like, for -- that would make it more welcoming for
 5 children rather than being a harsh clinical environment.
 6 **Q.** And may we please have a shout out for the military,
 7 Mr Grieve. Did, as in England, the military provide
 8 a great deal of help by way of logistical support,
 9 planning, the availability of -- making available
 10 vaccinators, and setting up vaccination centres and
 11 transport facilities in Scotland?
 12 **A.** Yeah, likewise in Scotland, the military played a hugely
 13 important role, and the ability to flex and for the
 14 programme to pivot and expand, not least to respond to
 15 Omicron, but equally, we turned the, what was the
 16 Scottish Exhibition and Conference Centre which was our
 17 version of a Nightingale Hospital, into a mass
 18 vaccination centre. The military led that work and
 19 delivered it at breakneck pace. So the military were
 20 hugely supportive and I'm immensely grateful for all
 21 they did.
 22 **Q.** Did they act as vaccinators as part of their functions
 23 in local vaccination sites?
 24 **A.** They did. They did indeed.
 25 **Q.** In England we've heard evidence that there were

48

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

6 **A.** Yeah.

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

9 **A.** Yeah.

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

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

49

1 **Q.** Please.

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

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

16 Just by way of example, we can see on this page:
 17 "Aim: increase vaccine uptake in all community
 18 groups".
 19 Area: communication.
 20 Drivers of inclusivity.
 21 And then importantly: "Health Board Actions":
 22 Provide marketing material, consider alternative
 23 communications, consider particularly use of social
 24 media and radio in a targeted way, local communication
 25 campaigns, sharing best practice.

51

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

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

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

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

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

25 **A.** Yes. If I may --

50

1 Then if we go down the page, to page 2, please, down
 2 the document to page 2, we can see the various limbs of,
 3 to use again the nomenclature, delivery plans.
 4 So accessibility of transport and clinics,
 5 engagement, staff training, data and evidence.

6 **A.** Yes.

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

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

52

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

53

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

55

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

54

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

56

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

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

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

18 **MR KEITH:** My Lady, that concludes --

19 **LADY HALLETT:** That completes your questions, Mr Keith?

20 **MR KEITH:** -- my questions.

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

22 **Questions from DR MITCHELL KC**

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

57

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

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

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

18 **A.** Exactly.

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

59

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

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

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

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

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

58

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

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

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

60

1 board?

2 **A.** Well, each health board had its own, and we supported
3 them, their own local comms to their community,
4 absolutely, but I suppose the point I'm making is the
5 differences weren't that major, so health boards didn't,
6 for example, we didn't have one health board vaccinating
7 priority group 4 whilst another health board was
8 vaccinating priority group 6. That didn't happen. All
9 health boards moved in lockstep with the approach -- so
10 there was core fundamentals which were agreed across all
11 health boards to avoid that very point you're making
12 to me.

13 **Q.** Moving on, it's further the experience of the Scottish
14 Covid Bereaved that vulnerable people within care home
15 settings were being invited to attend mass vaccination
16 centres. Firstly, I suppose, were you aware of that?

17 **A.** So do you mean residents or staff?

18 **Q.** Residents.

19 **A.** I'm not aware of residents being invited from a care
20 home to a vaccination centre. I can't recall of an
21 example of being made aware of that.

22 **Q.** Okay.

23 I then will simply move to the next question, which
24 was: what happened, if any, consideration was given to
25 ensuring that vulnerable people were not reliant on

61

1 had an extraordinarily difficult task, Mr Grieve, and
2 obviously performed it beautifully for the people of
3 Scotland. So thank you very much for what you did
4 during the pandemic and thank you for your help with the
5 Inquiry.

6 **THE WITNESS:** Thank you very much, my Lady.
7 (The witness withdrew)

8 **LADY HALLETT:** Thank you. Very well, I shall return at
9 11.40.
10 (11.26 am)

11 (A short break)

12 (11.40 am)

13 **LADY HALLETT:** Ms Stephenson.

14 **MS STEPHENSON:** My Lady, the next witness is
15 Professor Dr Gillian Richardson.

16 Please can the witness be sworn.

17 **PROFESSOR DR GILLIAN RICHARDSON (affirmed)**

18 **Questions from COUNSEL TO THE INQUIRY**

19 **LADY HALLETT:** Hope we haven't kept you waiting.

20 **THE WITNESS:** No, that's all right.

21 **MS STEPHENSON:** Please can you say your full name.

22 **A.** I'm Gillian Richardson.

23 **Q.** Thank you for attending to assist the Inquiry.

24 Just some preliminary matters. You made a witness
25 statement dated 16 August 2024, INQ000501330. It runs

63

1 attending mass vaccination centres? You referred in
2 your evidence earlier, for example, to the inclement
3 Scottish weather at winter. Was consideration given to
4 those sorts of things for vulnerable people attending
5 centres?

6 **A.** Yes, there were. And equally, as well as part of the
7 deployment going through the cohorts, there was often
8 a period at the tail end of that cohort of mop-up --
9 what we described as mop-up activity. So if, for
10 example, there was lower levels of uptake in the
11 clinically vulnerable, for example, in an area, we would
12 be exploring with the health board to see how much more
13 we could do, and that might include, for example, more
14 outreach activity.

15 **Q.** More, sorry?

16 **A.** Outreach activity.

17 **Q.** By that, meaning asking people to come in from other --

18 **A.** No.

19 **Q.** -- areas, or from other --

20 **A.** No, by that I mean vaccination teams going out to people
21 rather than people coming into the vaccine centre.

22 **DR MITCHELL:** I see.

23 My Lady, I'm obliged. Those are my questions.

24 **LADY HALLETT:** Thank you very much, Ms Mitchell.

25 Like your colleagues, the other SROs, you obviously

62

1 to 66 pages and 105 exhibits. It contains your
2 signature and a statement of truth. Can you confirm
3 that you have read that statement recently and its
4 contents are true?

5 **A.** I can.

6 **Q.** Thank you.

7 Before we get on to your professional background
8 I know you wish to say a few words about the efforts
9 made by your team.

10 **A.** Thanks so much.

11 I'd just like to thank my colleagues, really, in
12 NHS Wales and Welsh Government, including all the health
13 board Senior Responsible Owners, the directors of public
14 health, GPs and primary care contractors, Public Health
15 Wales, especially the Vaccine Preventable Diseases
16 programme and the Vaccine Surveillance Team, Wales Blood
17 and Transport Shared Services and the vaccine workforce,
18 who helped us to deliver the rollout of the vaccine
19 including third-sector colleagues, volunteers, and
20 military colleagues.

21 **Q.** On to your professional background. You have a medical
22 background. You initially worked as a GP, is that
23 right, before progressing through the public health and
24 research route to become a consultant in public health
25 medicine in the early 2000s?

64

1 A. That's correct.

2 Q. And you've held the positions of Director and NHS
3 Executive Director of Public Health of, in fact, two
4 health boards in Wales, and in 2017 became Deputy
5 Director of Policy, Research and International Health in
6 Public Health Wales; is that right?

7 A. That's right.

8 Q. Of most relevance to your evidence today, in late 2019,
9 you joined Welsh Government on an informal basis and was
10 that to cover, in the absence of a senior civil servant
11 in the Office of the Chief Medical Officer?

12 A. That's correct, yes.

13 Q. Effectively on loan from Public Health Wales?

14 A. Indeed, yeah.

15 Q. Your work, of course, intensified as the Covid pandemic
16 hit and you were at that time acting as a professional
17 adviser to the CMO, formally seconded, and eventually
18 stepping into the role of CMO Covid-19 response team
19 lead on Covid-19 vaccines in Wales; is that right?

20 A. It is.

21 Q. In early June 2020 it was agreed that a Covid-19
22 vaccination programme board would be established in
23 Wales which you would chair. Please can you explain
24 what the purpose of that board was.

25 A. The purpose of the board was to plan for the development

65

1 Medical Officer, and Claire Rowlands became the Senior
2 Responsible Owner.

3 A. That's right.

4 Q. However, did you continue to maintain your existing
5 relationships with the SROs in the other of the four
6 nations to attend meetings with them and to have a great
7 deal of input into the programme?

8 A. Yes, indeed. And to be the public communication CMO,
9 sort of, representative, yes.

10 Q. You describe in your statement you formed a small core
11 team in Welsh Government to coordinate vaccine planning
12 and infrastructure in the way you've described. You
13 also describe staffing difficulties within the Office of
14 the Chief Medical Officer for Wales. You were, as
15 you've explained, stepping into a role that had
16 previously not been occupied. And the pressures on
17 public health services during the pandemic no doubt
18 exacerbated those issues.

19 Did the staff shortages that you refer to in detail
20 in your statement prevent, in your view, the vaccination
21 programme planning running properly, or efficiently in
22 Wales?

23 A. No. I wouldn't say it did, because we had excellent
24 support from Public Health Wales' Vaccine Preventable
25 Diseases unit, Dr Richard Roberts then in charge and his

67

1 of a rollout of a vaccine. There were several candidate
2 vaccines, so we had to prepare for any of those to be
3 the one that would come first. We had to look at
4 delivery models for planning the rollout to the sectors
5 of the community that we had some prior notice but
6 hadn't quite been decided yet, but we knew that it was
7 going to the elderly population, it was going to be
8 particularly care home residents, health and social care
9 workers, and that it was likely to be an age-based
10 prioritisation rollout. So we were able to do tabletop
11 exercises with all the health boards where we all had
12 joint learning and basically did some tabletop planning.

13 Q. You became the Senior Responsible Owner for the Covid-19
14 vaccination programme, a position that you held until
15 2021. You point out that no formal appointment was made
16 for that role. How was it that your appointment came
17 about?

18 A. I think because I was the CMO lead for vaccines and at
19 that time it was quite a small team in Welsh Government.
20 We had, obviously, huge amount of efforts going on in
21 the Test, Trace and Protect functions as well as
22 emergency response, and I happened to have the most
23 experience with vaccination in the team, having worked
24 abroad on mass vaccination campaigns in Africa.

25 Q. And in April 2021, your role shifted to Deputy Chief

66

1 team, and also we had tremendous support from the
2 delivery unit of the NHS with Jeremy Griffiths stepping
3 into the Chief Operating Officer role.

4 Q. The Wales Covid-19 Vaccination Board, which you chaired,
5 had a number of aims. I'm not going to reel through all
6 of them, but were core aims to develop a delivery plan,
7 to manage and monitor vaccine uptake and equity of
8 access, and to ensure that stakeholders and partners
9 were informed on the progress of the development of the
10 plan?

11 A. Indeed, yes.

12 Q. Did you have a mission statement and if so, what was
13 that mission statement?

14 A. We did. Our mission statement was that we were to
15 immunise as many as possible, as swiftly as possible,
16 safely, with minimum vaccine waste.

17 Q. And there were certain UK-led workstreams, as they're
18 referred to in your statement, such as vaccine safety
19 and approval, prioritisation. That was being led
20 primarily by MHRA and JCVI, and is it right that that
21 work wasn't duplicated by your team, that the emphasis
22 of the vaccination board's workstreams was delivery?

23 A. It was. Although we did have a kind of
24 sub-prioritisation. We had our own Vaccine Clinical and
25 Prioritisation Group, so that if the JCVI guidance

68

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

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

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

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

22 **Q.** And that was to seek clarification?

23 **A.** Absolutely, yeah.

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

69

1 Wales, and the Audit Commission had produced a report
2 and, whilst it was complimentary, there were obviously
3 areas that we needed to look ahead to for the future.

4 And in terms of mainstreaming a programme, there are
5 phases when perhaps it is best to do that.

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

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

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

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

71

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

3 **A.** Mm-hm.

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

7 **A.** Yes.

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

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

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

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

22 **A.** Yes.

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

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

70

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

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

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

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

72

1 with a lack of parity across Wales, with different
2 people having different experiences of rollout?
3 **A.** It sometimes led to misunderstandings, it's true, but
4 the pace of the vaccination programme was so intense
5 that usually any disparities were extremely short-term,
6 because all of the health boards achieved -- our
7 priority groups 1 to 4 were all vaccinated and the offer
8 had been extended by mid-February.

9 So, in line with our first vaccination strategy.

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

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

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

73

1 please?

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

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

16 So we felt that we were -- we were nervous that we
17 would not have enough allocation should there be a
18 hundred per cent uptake, and in fact, for our care home
19 residents and over eighties, we came fairly close with
20 98% on the first dose. But in the event, BEIS were
21 always very generous in giving us the option, where
22 there were vaccine batches that were approaching the end
23 of their shelf life, we were often offered these, and
24 accepted them gladly.

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

75

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

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

11 **A.** Yes.

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

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

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

22 **A.** Yes.

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

74

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

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

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

16 **A.** There were.

17 **Q.** -- between the SROs?

18 **A.** Yes.

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

21 **A.** Yes.

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

24 **A.** Yes.

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

76

1 event of a future pandemic?

2 **A.** Yes, definitely. The meetings afforded us the
3 opportunity to involve our teams and to ask officials
4 for more guidance. But the WhatsApp day-to-day
5 conversations were an invaluable peer support mechanism
6 as well, and a chance to be honest, and transparent and
7 candid with each other.

8 **Q.** An issue arose between the nations as to a UK-wide
9 vaccine delivery plan.

10 **A.** Mm.

11 **Q.** In your statement you explain that a draft version was
12 shared by UK Government and SROs in each nation on
13 8 January with a request for review and contribution
14 from Wales, Scotland and Northern Ireland. Was it
15 possible for Wales to agree a joint UK plan at that
16 time?

17 **A.** It could have been had there been earlier notice, but we
18 were informed about it very late on the Monday before it
19 was due to be published, and we only actually received
20 the draft version in full on the Friday evening, by
21 which time, obviously, that meant a very, very short
22 space of time to consider it and no time for
23 consultation.

24 It also meant that, you know, because, in Wales, we
25 have a duty under the Welsh Language Act to produce

77

1 which was first published on 11 January 2021.

2 **A.** Yes.

3 **Q.** I know that there were revisions to it, but this initial
4 foundational document.

5 Perhaps if we could take a look, INQ000410079.
6 This the strategy itself.

7 And if we scroll down, please, to page 4, section 2,
8 an "Overview of where we are now", it sets out the key
9 areas -- if we could just come back out, please.

10 It sets out the key areas that the strategy is
11 focused on: to work closely with the UK Government on
12 supply, to make sure that there is a proper vaccination
13 infrastructure, and keeping up to date and informed. It
14 sets out the scale of the challenge: the biggest
15 vaccination programme in history.

16 The strategy at paragraph 2 states that:
17 "It is important to be clear about the supply
18 challenges ... the logistics around first vaccine in
19 particular ..."

20 And that:
21 "Health boards are operating to a 'just in time'
22 vaccine delivery mechanism as supply arrives."

23 Can you explain what was meant by that, please.

24 **A.** Yes. So we were very concerned obviously about the
25 Pfizer vaccine's storage requirements and we had in fact

79

1 every public document bilingually, so to have put our
2 own stuff in, and also translated all that had not
3 actually yet been completely finalised, from the
4 UK Government would have been incredibly difficult.

5 **Q.** In your view would there have been -- because Wales, of
6 course, went on to publish its own strategy.

7 **A.** Yes.

8 **Q.** Would there have been benefit in a four-nations plan or
9 given the different deployment approaches, was it
10 sensible to have separate plans?

11 **A.** I think there would have been strength from a public
12 confidence aspect to have had an overarching
13 four-nations introduction, and then a section for each
14 country, but as it was presented to us at that time, and
15 I appreciate that, you know, the matter was pressing to
16 get milestones for delivery out. However, it came
17 across as an incredibly Anglo-centric document that I
18 don't believe any of the four nations signed up to
19 eventually.

20 **Q.** So presumably, if the scenario arose in the future, it's
21 earlier collaboration and notice --

22 **A.** Absolutely.

23 **Q.** -- which would be helpful?

24 **A.** Yes.

25 **Q.** Moving on, then, to that Wales vaccination strategy,

78

1 entered into an agreement with BEIS and Pfizer to have
2 direct deliveries to Wales, and we were really, you
3 know, finding out about that vaccine in the first
4 instance.

5 But because the supply chain was very variable at
6 that time, and if a -- supposing we had a batch that
7 didn't receive approval by the MHRA, that could be half
8 of our supply for that week. So we operated a system
9 with all the health boards where they could order their
10 vaccines and we would deploy them so that they were --
11 they had a continuous supply of everything we had,
12 basically, coming into Wales. And that way it enabled
13 them to deploy swiftly as well, whatever we were given.

14 **Q.** You mentioned a memorandum of understanding . Perhaps we
15 could deal with that now.

16 **A.** Yes.

17 **Q.** That was a memorandum of understanding between the Welsh
18 Government and BEIS in respect of delivery of the Pfizer
19 vaccine. Could you explain in summary what that
20 understanding was, what it allowed Wales to do
21 differently?

22 **A.** It meant that our supplies did not have to go through
23 Public Health England and it meant that they could come
24 straight to Wales and be deployed immediately. There
25 were very strict regulations on the amount of times

80

1 a vaccine could be moved, where it was to be stored,
 2 once it was constituted how long it could be used for --
 3 6 hours, for instance.
 4 So cutting out the middle man, if you like, helped
 5 Wales to speed up our vaccination delivery --
 6 **Q.** And was that particularly needed in Wales because some
 7 of the rural areas --
 8 **A.** Absolutely, yes.
 9 **Q.** -- being harder to reach and meaning that an extra
 10 transfer would make it unviable?
 11 **A.** Absolutely, we just didn't have the luxury of that extra
 12 transfer.
 13 **Q.** So returning to that document, please, at page 8, to
 14 briefly look at the model that was adopted. We see,
 15 just scanning here, that there is a plan for mixed
 16 delivery through mass vaccination centres, primary care
 17 surgeries, and mobile units, and an aim to have one
 18 vaccine centre in each county of Wales, and recognising
 19 that local convenience is served by reaching communities
 20 through primary care, and that's also safer for older
 21 and vulnerable groups?
 22 **A.** Yes.
 23 **Q.** At this point, 100 GP practices had been engaged and
 24 there were plans to get up to 250 before the end of
 25 January, and you also mention the importance of

81

1 really, basically, through a whole weekend and week to
 2 convert our child health immunisation system, which was
 3 an integrated call/recall, et cetera, and data capture
 4 system, and adapt that for the whole of the adult
 5 population in Wales.
 6 **Q.** So this was operational at the time of the publication
 7 of this document which was 11 January?
 8 **A.** Yes.
 9 **Q.** And how effective was that system in particular in
 10 allowing you to monitor uptake and any gaps in uptake,
 11 in particular groups?
 12 **A.** It was extremely helpful, and it enabled us to look at
 13 each health board's performance in terms of their areas,
 14 their GP clusters, for example, local networks of GPs,
 15 their gender, their age ranges, their categories, what
 16 cohort somebody was in that had been immunised, and then
 17 later, as we were able to develop better systems to look
 18 at ethnicity and other protected characteristics, it
 19 enabled us to have an enhanced vaccination report,
 20 enhanced from the daily so that we were able to look at
 21 areas that may be doing very well, or not doing well
 22 with particular groups.
 23 **Q.** Thank you. We can take that document down.
 24 The strategy, we needn't go to the page, but it also
 25 states that at that point, there was only 1% of wastage

83

1 community pharmacies.
 2 If we could look at page 9, please, this the
 3 mention, at the top of the page, of mobile units; were
 4 they already being used in order to reach --
 5 **A.** Yes.
 6 **Q.** -- care homes --
 7 **A.** Indeed.
 8 **Q.** -- and other vulnerable groups?
 9 **A.** Yes, and shortly after this strategy was published, by
 10 26 January, we had over 300 -- well, 387 GPs came on
 11 board, 33 hospitals, 38 mobile teams and 52 mass
 12 vaccination centres, and that represented 9% of the
 13 population being covered with their first dose. And we
 14 also had a particular target to immunise all 16,000 of
 15 our frontline Welsh ambulance staff as part of the
 16 essential infrastructure resilience for the NHS.
 17 **Q.** We see there as well reference to how appointments are
 18 made. In Wales was it the Welsh immunisation system --
 19 **A.** Yes.
 20 **Q.** -- for scheduling appointments and also recording and
 21 reporting on vaccination activity, was it all in one
 22 system?
 23 **A.** It was an integrated system developed at haste by the
 24 National Wales Information Service, now renamed, but
 25 a lady, Jill Davidson, and her team, worked nonstop

82

1 in the first few weeks of the national vaccination
 2 programme, and you go into some detail in your statement
 3 about the fact that it's your view that Wales maintained
 4 extremely low levels of vaccine waste.
 5 **A.** Yes.
 6 **Q.** How was this achieved in Wales, please?
 7 **A.** We had a pharmaceutical team with very extensive
 8 training in the use of the vaccine, and in supporting
 9 health boards. So every hospital pharmacy team was
 10 involved, every health board had pharmaceutical leads.
 11 So our team in Welsh Government would work with them to
 12 make sure that the vaccine was constituted correctly.
 13 Many of our mass vaccination centres, or all, in fact,
 14 I think had pharmacists on site so to ensure good
 15 preparation.
 16 We also had systems so that at the end of the day,
 17 we had end-of-day doses and we had reserve lists, we had
 18 also a means of not unbottling and reconstituting
 19 vaccines that did not -- were not going to be needed.
 20 So about an hour from the closing centre times, the
 21 management of the centre would look at the queues, would
 22 make sure that the number of vaccination stations --
 23 because there could be, say, 30 in a large centre --
 24 that they were slimmed down to maybe five, you know, and
 25 below. So just for the last half hour we were actually

84

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

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

9 **A.** Yes.

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

11 This is the Vaccination Equity Strategy for Wales.

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

16 **Q.** And published in March 2021.

17 **A.** Yes.

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

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

85

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

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

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

87

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

10 Thank you. We can take that section down.

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

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

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

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

86

1 meeting on 22 March 2021.

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

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

12 **A.** Yes.

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

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

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

88

1 **A.** No, okay.

2 **Q.** -- it wouldn't be proportionate, but examples: ensuring
3 information was available in different languages,
4 providing translation services, ensuring information was
5 in accessible or in Easy Read format for people with
6 disabilities?

7 **A.** Yes.

8 **Q.** Community transport options, pop-up centres, use of
9 trusted voices in communities to spread information.
10 To add to that list, just a couple of matters I want
11 to ask you in more detail about. Within the list is
12 reassurance for people that their information would not
13 be shared with immigration authorities --

14 **A.** Yes.

15 **Q.** -- if that might be a barrier to them seeking
16 vaccination.

17 **A.** Yes.

18 **Q.** Can you explain, was the situation the same in Wales as
19 in client for people with uncertain immigration status
20 when it came to the charging provisions that might apply
21 to healthcare?

22 **A.** No. I think it's fair to say that Wales never
23 subscribed to the hostile environment policy in that
24 sense of ensuring that our data -- our clinical data on
25 the patients was never shared with the Home Office. We

89

1 to people or that they may have lacked confidence in
2 information -- that in -- their information wasn't going
3 to be shared, as the government had assured them it
4 wouldn't be.

5 **A.** Yes.

6 **Q.** So are you confident that in Wales enough was done to
7 let people who had uncertain immigration status and
8 might be worried about that know that it wouldn't apply?

9 **A.** There's always more. There's always more that can be
10 done. But particularly, you know, the fact that things
11 like -- you know, people with maternities are very
12 nervous, if they've been in England first, that they
13 will be charged.

14 So all kinds of layers of misunderstanding that the
15 four NHS systems are not actually identical can arise.
16 So we tried our hardest to address those issues.

17 **LADY HALLETT:** I'm sorry, I couldn't quite hear and I don't
18 think the stenographer did, either. People with?

19 **A.** Maternities, for instance, people who -- people are very
20 concerned that if you are an asylum seeker you might be
21 charged for your hospital treatment if you have
22 a maternity.

23 **LADY HALLETT:** I'm so sorry, I'm not following. If you have
24 maternity?

25 **A.** If you have a baby in a hospital, will you be charged,

91

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

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

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

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

16 There was still a lack of vaccine confidence,
17 especially amongst those that perhaps had not come
18 directly to Wales, but I do believe that the various
19 agencies together made a really helpful impact for that
20 group.

21 **Q.** To be clear, the vaccination programme and treatment for
22 Covid-19 was, of course, exempt in England from those --

23 **A.** Yes.

24 **Q.** -- charging provisions, but the difficulty was that
25 there are concerns that that message didn't get through

90

1 basically.

2 **LADY HALLETT:** Oh, I see.

3 I follow. Thank you.

4 **MS STEPHENSON:** Just one other point of difference I want to
5 ask you about when it comes to care. In Wales, was
6 there a requirement to be registered with a GP or to
7 have an NHS number in order to obtain vaccine?

8 **A.** No.

9 **Q.** A particular challenge in Wales was rural communities.
10 What steps were in place to ensure that they had proper
11 access to vaccines?

12 **A.** All of our health boards have been working with their
13 rural communities for many years. Our NHS is fortunate
14 in that we haven't had a reorganisation since 2009. So
15 in fact, you know, our health boards know their
16 communities very well. They've worked very closely with
17 their general practitioners and other primary care
18 contractors, and with community health services.

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

92

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

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

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

8 **A.** Yes.

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

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

93

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

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

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

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

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

15 **A.** Yes.

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

19 **A.** Yes.

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

22 **A.** Yes.

23 **Q.** How did you do that?

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

95

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

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

11 **A.** Yes.

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

17 **A.** Yes.

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

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

94

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

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

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

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

96

1 Q. There was also a flexible approach adopted on the JCVI
2 guidance around learning disabilities --

3 A. Yes.

4 Q. -- and the distinction between people with a severe and
5 profound or mild or moderate learning disability. Did
6 the Welsh Moral and Ethical Advisory Group advise on
7 that issue, and what was the outcome?

8 A. They did, but we also had learning disability charity
9 members on our stakeholder forum and on our Vaccine
10 Equity Committee. So there were a variety of sources of
11 advice on that, including from members with learning
12 disabilities themselves.

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

24 So we decided that, again, we would have
25 a permissive approach. Our minister was at pains that
97

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

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

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

23 So we felt that it would need to be continuously
24 monitored because the workforces are very rapidly
25 changing, workforces are high turnover, but our Chief of
99

1 no one was to be left behind, and it was very difficult
2 to strictly define who was severe or profoundly learning
3 disabled.

4 Q. So it captured anybody, then, with a learning
5 disability?

6 A. It captured anybody that we could identify as having
7 a learning disability, and we knew that even for those
8 with mild to moderate, there were much poorer health
9 outcomes, for instance, just generally in terms of their
10 healthcare.

11 Q. A different topic entirely, please: Vaccination as
12 a Condition of Deployment --

13 A. Yes.

14 Q. -- which of course was not implemented in Wales.

15 A. No.

16 Q. That was a ministerial decision?

17 A. Yes.

18 Q. But it's one that you had some input to because you
19 contributed to a Cabinet briefing paper in 2021 about
20 the advantages and disadvantages of the approach. Can
21 you explain, please, why Wales did not go down that
22 route?

23 A. Yes. It's interesting, earlier on in the week Heidi
24 Larson talked about the fact that making smallpox
25 vaccination mandatory actually led to the first anti-vax
98

1 Social Services, our Chief Medical Officer, regularly
2 wrote to the care sector to, you know, encourage them,
3 to continue with this extremely high level of take-up
4 and to congratulate them, really, on that.

5 Q. Why do you think that Wales was able to achieve that
6 higher level take-up amongst care home workers in
7 particular?

8 A. Our very first initial strategy had set out that we
9 would -- we aimed to immunise our care home workers at
10 the same rate as our care home residents, because it was
11 an environment in which we needed to protect everybody.
12 In particular to make sure that carers didn't come in to
13 work and infect the residents.

14 Q. Moving on, VDPS, please.

15 A. Yes.

16 Q. Which was, of course, a matter reserved to the
17 UK Government. But are you able to give your views
18 on --

19 A. I am.

20 Q. -- how that scheme operated in Wales?

21 A. Yes. Obviously it's not a devolved matter, and the
22 Welsh Government, this was not their opinion, but my own
23 personal opinion is that any scheme that looks at
24 compensation needs to be a sliding scale and not
25 a threshold. It needs to be very responsive and it
100

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

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

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

22 **A.** Mm, mm.

23 **Q.** The MHRA Yellow Card Scheme --

24 **A.** Yes.

25 **Q.** -- of course operated in Wales.

101

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

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

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

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

103

1 **A.** It did.

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

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

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

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

102

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

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

16 **MS STEPHENSON:** Thank you. Those are my questions.

17 **LADY HALLETT:** Thank you very much, Ms Stephenson.

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

20 Questions from MR DAYLE

21 **MR DAYLE:** [Microphone not switched on].

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

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

104

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

6 **A.** I agree.

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

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

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

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

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

105

1 **THE WITNESS:** Thank you.

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

4 **THE WITNESS:** Thank you.

5 **(The witness withdrew)**

6 **LADY HALLETT:** I shall return at 1.45.

7 **(12.46 pm)**

8 **(The Short Adjournment)**

9 **(1.45 pm)**

10 **LADY HALLETT:** Ms Stephenson.

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

13 **DR NARESH CHADA (affirmed)**

14 **Questions from COUNSEL TO THE INQUIRY**

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

17 **MS STEPHENSON:** Please can you say your full name.

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

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

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

107

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

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

17 **MR DAYLE:** Very well. Thank you.

18 **LADY HALLETT:** Thank you, Mr Dayle.

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

22 **THE WITNESS:** Absolutely.

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

106

1 contents are true?

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

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

6 **A.** Yes, that is correct.

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

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

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

20 **A.** Yes, I did.

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

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

108

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

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

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

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

109

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

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

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

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

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

111

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

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

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

15 **A.** Yes, certainly.

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

110

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

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

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

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

112

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

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

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

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

113

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

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

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

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

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

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

115

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

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

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

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

114

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

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

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

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

24 **A.** Yes, that's correct, yes.

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

116

1 deal with matters like pharmacies, storage and
 2 distribution?
 3 **A.** Yes.
 4 **Q.** Communications, logistics, workforce?
 5 **A.** Yes, yes.
 6 **Q.** Practical, operational matters?
 7 **A.** Yes, we would get reports on all of those areas to the
 8 Oversight Board and then the Implementation Group was
 9 much more involved in the day-to-day nitty-gritty of how
 10 they were actually going to get the programme up and
 11 running and then through all the various iterations of
 12 the programme as we worked our way through the different
 13 priority groups, basically.
 14 **Q.** There was an effort, the Inquiry has heard, to create
 15 a joint UK vaccine delivery plan in those early days at
 16 the beginning of January 2021, jointly between all four
 17 nations. You explain in your statement that there
 18 wasn't time for devolved nations to contribute.
 19 If we could, in fact, just look at your thoughts at
 20 the time, INQ000477804, page 15, please, at 13:52:25, if
 21 we could zoom in.
 22 So the suggestion has been made there about feeding
 23 into this joint document and you were saying at the time
 24 to DHC:
 25 "We really want to work towards a joint strategic
 117

1 know, put it into place as quickly as possible, as they
 2 could.
 3 But nevertheless, I mean, you know, the document
 4 went out there. It was published. And I think at least
 5 very quickly it gave the public an idea of what was
 6 happening at a UK-wide level, you know, both in terms
 7 of, you know, the acquisition of the vaccine and what
 8 the ongoing plans were.
 9 So, you know, for that moment in time, perhaps more
 10 could have been done to get contributions from the
 11 different devolved administrations.
 12 I think my longer-term view is it probably didn't
 13 make much difference in the end, and yes, I think it is
 14 important, though, for us to have that collegiate view
 15 of things, and for obviously each of the devolved
 16 administrations to have their opportunity to be able to
 17 contribute, but I just think sometimes the timescales in
 18 that particular one just weren't sufficient at that
 19 time.
 20 **Q.** Did Northern Ireland create a public vaccine plan or
 21 vaccine strategy document of its own?
 22 **A.** Well, we certainly had a vaccine plan that we worked to
 23 from an operational level. I just can't recall at this
 24 minute whether we actually published one online, so to
 25 speak.
 119

1 document and we tried to feed ... back as best we could
 2 on a very short timescale."
 3 Could you explain, first, what the difficulties
 4 were -- we can take that down now, thank you -- which
 5 meant that you were expressing in this WhatsApp group to
 6 the SROs that you wanted to contribute but you just
 7 couldn't in the time available? What happened?
 8 **A.** Yes, I mean, this particular document was going to be
 9 produced on behalf of, you know, the wider UK, quite
 10 early on in the vaccination programme. So, as you can
 11 sort of see from the dates there, you know, it was
 12 10 January, so we were less than a month into the
 13 proceeded, and we also had the intervening Christmas
 14 period as well.
 15 I think ideally each of the devolved
 16 administrations, and everyone has got their own
 17 particular view on this, would have liked to have been
 18 able to contribute a bit more fully to the document.
 19 So, you know, particularly in terms of some of the
 20 detail around their delivery plans or the number of
 21 vaccination sites they had, et cetera. But I think it
 22 was just because of the very, very tight timescale,
 23 perhaps the WhatsApp group demonstrated that perhaps it
 24 was a little bit disquiet about that and, you know, they
 25 just weren't able to put what they wanted to do -- you
 118

1 But what I would say is that we were always
 2 communicating to the public what our plans were for the
 3 vaccination programme in Northern Ireland, and how it
 4 was going to be deployed, and how we were looking
 5 forward to that. So whether there was an actual
 6 document I just can't recall just at this minute, but
 7 whether you look at what we were actually trying to do
 8 in terms of communicating openly, both with the public
 9 and indeed, you know, the wider society in Northern
 10 Ireland, I think we were very open about what we were
 11 doing around vaccination planning.
 12 So, you know, there was communications obviously by
 13 Dr Patricia Donnelly, the Chief Medical Officer, the
 14 Chief Scientific Advisor. So people would have known
 15 very clearly what we were doing. And there was a lot of
 16 information about what we were doing around vaccination
 17 on the Northern Ireland website as well, NI Direct.
 18 **Q.** There isn't such a plan exhibit in the documents that
 19 you have provided to the Inquiry.
 20 **A.** Mm.
 21 **Q.** On the basis that there wasn't a public-facing document
 22 of that kind, do you think in the future it would be
 23 helpful to pull together the information that you've
 24 talked about being available online and the
 25 announcements in a public-facing strategy document?
 120

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

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

15 **A.** Yeah.

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

121

1 **A.** Yes. Absolutely.

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

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

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

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

123

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

3 **A.** Yes, I think so.

4 **Q.** Thank you.

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

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

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

19 **Q.** Thank you.

20 And that document can come down, thank you.

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

122

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

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

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

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

124

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

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

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

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

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

125

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

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

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

127

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

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

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

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

126

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

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

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

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

128

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

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

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

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

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

129

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

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

12 **A.** Rurality.

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

15 **A.** Yes, sorry, pronunciation there. Rurality.

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

18 **A.** Yes.

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

131

1 homelessness and deprivation who might have lower
2 vaccine uptake.

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

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

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

130

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

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

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

23 **MS STEPHENSON:** Thank you, those are my questions.

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

132

1 **Questions from MR WILCOCK KC**

2 **MR WILCOCK:** Good afternoon, Dr Chada.

3 **A.** Thank you.

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

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

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

133

1 of infection.

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

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

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

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

135

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

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

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

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

134

1 and, not least, Covid itself.

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

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

14 **LADY HALLETT:** Certainly, Mr Wilcock.

15 **MR WILCOCK:** Thank you.

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

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

136

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

9 **MR WILCOCK:** Thank you very much.

10 **LADY HALLETT:** I have the point, Mr Wilcock.

11 **MR WILCOCK:** Thank you.

12 **LADY HALLETT:** Mr Weaver.

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

16 **Questions from MR WEAVER**

17 **MR WEAVER:** Thank you, my Lady.

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

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

137

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

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

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

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

139

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

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

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

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

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

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

138

1 just had.

2 **Q.** Thank you, Dr Chada.

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

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

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

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

140

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

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

8 **MR WEAVER:** Thank you, Dr Chada.

9 Thank you, my Lady.

10 **LADY HALLETT:** Thank you very much, Mr Weaver.

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

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

15 **THE WITNESS:** Yes, I have.

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

19 **THE WITNESS:** Yes.

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

22 **THE WITNESS:** Thank you.

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

25 **THE WITNESS:** Yes, we were quite badly affected by the
141

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

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

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

10 **DR KASSTAN-DABUSH:** That's correct.

11 **Q.** Dr Chantler?

12 **DR CHANTLER:** Yes, that's correct.

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

21 **DR KASSTAN-DABUSH:** That's correct.

22 **Q.** And you've had many years of experience in this field,
23 and over the years you've given considerable support to
24 public health agencies in the United Kingdom and the US
25 on, shortly, how to respond in the face of epidemics and
143

1 storm.

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

3 **THE WITNESS:** So, yes, some people very seriously affected.

4 And I'm sorry for that. I had a few loose tiles blown
5 off, so not so bad, thanks.

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

9 Thank you very much for your help, anyway.

10 **THE WITNESS:** Thank you.

11 **(The witness withdrew)**

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

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

17 **DR BEN KASSTAN-DABUSH (affirmed)**

18 **DR TRACEY CHANTLER (sworn)**

19 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 4**

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

22 **DR KASSTAN-DABUSH:** Benjamin Kasstan-Dabush.

23 **Q.** And Dr Chantler?

24 **DR CHANTLER:** Tracey Chantler.

25 **Q.** Thank you very much.
142

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

6 **DR KASSTAN-DABUSH:** That's right.

7 **Q.** Is that a fair summary?

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

12 **DR CHANTLER:** That's correct.

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

17 **DR CHANTLER:** Yes, that's correct.

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

23 **DR CHANTLER:** That's correct.

24 **Q.** And was your report greatly assisted by other experts,
25 both in the London School of Hygiene and Tropical
144

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

6 **DR CHANTLER:** Correct.

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

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

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

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

145

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

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

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

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

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

147

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

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

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

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

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

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

146

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

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

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

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

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

25 **DR CHANTLER:** Mm.

148

1 Q. So it's a bit like going down a tree, or perhaps going
2 up a tree -- well, maybe going down a tree. You get to
3 the point where at local level you've got to focus on
4 the primary healthcare provision and the logistical and
5 delivery aspects away from Edinburgh, London, Belfast,
6 and Cardiff.

7 DR CHANTLER: Mm.

8 Q. Do you express views as to whether or not, at the
9 beginning of this process, the important part by which
10 vaccines were delivered, the important bodies by which
11 vaccines were delivered, were properly and fully engaged
12 enough in the planning?

13 DR CHANTLER: Mm.

14 Q. You refer at pages 11 and 12 to whether or not, in
15 England, Public Health England was sufficiently involved
16 in the planning for the procurement of vaccines and in
17 the operational work done by the VTF?

18 DR CHANTLER: I think the point we want to raise in our
19 report is that it's that formal responsibility. So we
20 have, since writing the report, become aware that Public
21 Health England, now UKHSA, were probably feeding into
22 the Vaccine Taskforce meetings and providing input, but
23 they formally didn't join that Vaccine Taskforce until
24 September 2020, which, from our point of view, given
25 that UKHSA and NHS England are -- those with the primary
149

1 DR CHANTLER: I think what was key from the evaluation of
2 the H1N1 pandemic plan was the importance of alignment
3 and those points you've touched on already, making sure
4 that the devolved nations have the same procurement
5 processes, the consistent messages, the working very
6 closely together. I think that was done very, very
7 well.

8 Q. Was that H1N1 epidemic -- did it improve the
9 collaborative links within the United Kingdom? So in
10 the course of responding to H1N1, had each of the
11 devolved nations worked relatively closely together, and
12 therefore there was, to use a terrible modern
13 expression -- was the learning embedded from the
14 response to that earlier -- (overspeaking) --

15 DR CHANTLER: Yeah, I think it definitely was embedded in
16 the response to the Covid-19 pandemic in that, kind of,
17 focus on making sure that there's alignment across the
18 devolved administrations, in the overarching points
19 around the prioritisation, the procurement of vaccines.
20 So those, kind of, high-level decisions that need to be
21 made. There was -- there were differences, and I'm sure
22 we're going to go on to look at that in terms of
23 implementation and I think also consultation at the
24 political level of the devolved administrations.
25 I think there was some learning that could have been
151

1 responsibility for delivering routine vaccination
2 programmes, feels there's an omission, and that
3 expertise could be more formally included at an earlier
4 stage in England.

5 Q. We have, since your report was prepared, received
6 evidence to the effect that Public Health England may
7 have been a member of the programme board of the VTF --

8 DR CHANTLER: Mm.

9 Q. -- which was one of the two emanations of the Vaccine
10 Taskforce from May 2020. If that is -- if that does
11 prove to be the position, would you regard that as
12 a sufficient involvement in terms of being engaged in
13 the pre-delivery planning?

14 DR CHANTLER: I think it's heartening to know that. I think
15 it would have been better if they were involved in the
16 formal taskforce overall, given that they are very
17 responsible for routine, have the primary responsibility
18 for routine immunisation programmes. So I think that,
19 from my perspective, the earlier involvement, the
20 better. But yes, it is reassuring.

21 Q. And from the standpoint of seeing how well set up the
22 overarching process was, to what extent do you assess
23 that the planning and the initial delivery of vaccines
24 across the United Kingdom did benefit from learning from
25 the H1N1 2009 flu vaccination programme, paragraph 15?
150

1 taken on that wasn't taken on.

2 Q. And within that structure, was there a high degree of
3 collaboration between each of the respective nations'
4 public health agencies, and the bodies in London
5 responsible for procurement, and the bodies in each
6 nation responsible for delivery?

7 DR CHANTLER: I would say yes.

8 Q. And at paragraph 18 on page 11, you refer to the rapid
9 allocation of sufficient financial resources. In
10 general terms, do you note that the Covid-19 vaccination
11 programmes in each of the four nations were particularly
12 notable for the way in which they were funded by
13 comparison to, perhaps, difficulties in funding
14 associated with routine vaccination programmes?

15 DR CHANTLER: Yeah, I want to clarify on this point, what
16 we're talking about here in terms of this additional
17 funding is the funding -- that it became very apparent,
18 in order to do additional outreach and to address causes
19 of disparity in uptake, funding was made available to,
20 you know, service providers, and this was quite
21 different from routine programmes. So that was -- and
22 this enabled these delivery of novel pathways, and for
23 closer collaboration with community partners.

24 And as far as we -- we don't know for certain, but
25 we're assuming that the Barnett formula would have been
152

1 used to make sure that that funding was equally
2 available across the devolved administrations.
3 Where there is -- could be improvement there is
4 embedding more evaluation to see how that funding
5 resulted in interventions that improved uptake that
6 could then be carried forward and used in the routine
7 programme.

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

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

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

153

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

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

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

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

155

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

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

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

25 **Q.** Did that absence of fully functioning evaluative

154

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

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

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

23 **DR KASSTAN-DABUSH:** That sounds fair.

24 **DR CHANTLER:** -- (overspeaking) --

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

156

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

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

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

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

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

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

157

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

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

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

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

19 **DR KASSTAN-DABUSH:** Absolutely.

20 **Q.** All right.

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

159

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

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

14 **DR KASSTAN-DABUSH:** Absolutely, yeah.

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

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

158

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

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

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

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

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

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

22 Sorry, I hope you were warned we take breaks.

23 (3.03 pm)

(A short break)

24 (3.20 pm)

160

1 **LADY HALLETT:** Mr Keith.

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

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

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

161

1 category for mental or physical disability, was there?

2 **DR KASSTAN-DABUSH:** No.

3 **Q.** There was no general category for those who suffer from
4 learning disability but there was a categorisation for
5 those who have severe and profound learning disability,
6 cohort 6, and I think those who have Down syndrome,
7 cohort 4.

8 **DR KASSTAN-DABUSH:** Correct.

9 **Q.** Did the issue of prioritisation for those suffering from
10 learning disability give rise also to definitional
11 problems and difficulties with identifying who should
12 receive an offer?

13 **DR KASSTAN-DABUSH:** And again, the consistency against the
14 four nations of how do you identify that cohort for
15 vaccination. For example, in England ultimately the
16 Learning Disability Register was used as one resource,
17 but obviously that is not in operation in the same way
18 across all four nations. So that could be something to
19 explore in the future, of, again, a UK-aligned approach
20 to a disability register.

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

163

1 quite highly in the list in phase I.

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

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

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

23 But having something may help.

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

162

1 **Q.** Frontline health and social careworkers, page 23.

2 Frontline social careworkers were a priority group for
3 vaccination in cohort 2?

4 **DR KASSTAN-DABUSH:** Yes.

5 **Q.** Obviously, careworkers in residential care homes were in
6 cohort 1?

7 **DR KASSTAN-DABUSH:** Mm-hm.

8 **Q.** But there was no general priority for health and social
9 care workers. Did England and Wales maintain a central
10 register of social care workers which would enable those
11 prioritised groups to be offered a vaccine?

12 **DR KASSTAN-DABUSH:** I mean, it -- no, the social care sector
13 in England is incredibly fragmented, broken up across
14 lots of different services and sectors, so again the
15 ability to identify that cohort based on eligibility
16 wasn't there.

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

164

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

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

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

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

165

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

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

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

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

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

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

18 **DR KASSTAN-DABUSH:** (Witness nodded)

19 **Q.** -- and started vaccinating outside SAIS?

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

167

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

2 **DR KASSTAN-DABUSH:** School Aged Immunisation Services.

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

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

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

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

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

166

1 cohorts, but is there anything on the ...

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

15 **Q.** All right.

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

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

168

1 routinely record membership of certain health inclusion
2 groups.

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

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

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

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

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

169

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

4 "This type of flexible provision ..."

5 **DR CHANTLER:** Okay, yes, sure.

6 **Q.** So it's the subject of vaccinators.

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

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

171

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

8 **Q.** All right.

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

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

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

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

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

170

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

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

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

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

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

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

172

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

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

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

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

173

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

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

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

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

175

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

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

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

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

174

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

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

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

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

176

1 be done to improve and to tailor services.
 2 I'm not saying that you then possibly need to go
 3 away with the health professionals to design that but
 4 then continuously getting input and I think that's
 5 what's going to be core, moving forward, is that kind of
 6 strategic community engagement at the -- yeah,
 7 appropriate level at each kind of
 8 local/regional/national level.
 9 Ben, I don't know if you want to add anything there.
 10 **DR KASSTAN-DABUSH:** No, I don't think so, other than, you
 11 know, what's very -- what's often not clear is the
 12 accountability that such groups have to measure progress
 13 and changes and upticks, and so I think that comes
 14 together with such groups.
 15 **Q.** If they're delivering tailored delivery procedures and
 16 processes and they know their local communities and
 17 they're coming up with the goods, does accountability
 18 matter? I mean, is that not just a heightened
 19 unnecessary degree of administrative process?
 20 **DR KASSTAN-DABUSH:** I don't know if I agree because I think
 21 it's really crucial to ensure that changes happen when
 22 they're needed, to learn from past limitations, shall we
 23 say, or failings, and create an agenda for change in
 24 partnership with those underserved groups.
 25 **Q.** All right. Northern Ireland. You refer on page 36,
 177

1 a greater role than in other devolved administrations,
 2 but there's definitely scope and there's discussions
 3 even now ongoing for the routine programme of
 4 formalising the contribution of community pharmacies to
 5 a routine programme which I think will benefit future
 6 pandemic preparedness.
 7 **Q.** You also highlight the fact that Northern Ireland was
 8 the first UK nation to deliver Pfizer vaccines in care
 9 homes via a trust mobile team.
 10 Obviously, there were complexities, as you said,
 11 surrounding the Pfizer vaccine because of the need to
 12 keep it frozen, but it would appear that their mobile --
 13 which is necessarily a highly tailored specific process
 14 of delivery -- got going very early on, and achieved
 15 a great deal within a relatively short space of time.
 16 **DR CHANTLER:** Yes, agree.
 17 **Q.** In Scotland, page 37, you note the National Vaccination
 18 Inclusive Steering Group, the blended approach to
 19 delivery, and of course, the fact that for winter 2021,
 20 there was an integrated flu and Covid vaccination
 21 programme.
 22 **DR CHANTLER:** Mm.
 23 **Q.** How did that integration of programmes assist in the
 24 speedy delivery to, in particular, marginalised
 25 communities?
 179

1 Dr Chantler, to the fact that the Department of Health
 2 established a Northern Ireland Covid-19 Vaccination
 3 Programme Oversight Board and that delivery was
 4 initially managed through trust-led mass vaccination
 5 sites and the GP surgery teams, and then the community
 6 pharmacies came on board.
 7 Do you assess that there were a sufficient number of
 8 community and regional-based entities and people in the
 9 Northern Ireland system to be able to deliver
 10 necessarily tailored, specific delivery plans?
 11 **DR CHANTLER:** I mean, this falls back to the "we don't have
 12 as much access to evaluations on the Northern Ireland
 13 devolved administration". One thing I do want to
 14 highlight with Northern Ireland is their very novel
 15 approach of a twin-track approach which you can see in
 16 paragraph 116(c), whereby different priority groups
 17 could either go to the trust or to the GP surgery at the
 18 same time, which was a really good way of offering at
 19 a fast pace and that was quite directive and clear to
 20 the different priority groups. So I think that was
 21 a really, some learning that could be taken forward.
 22 Community pharmacies did come on later and then some
 23 of the issues, the limitations we've talked about, the
 24 complexities of delivering Pfizer and other vaccines,
 25 and I think it was probably in England where they played
 178

1 **DR CHANTLER:** I think what we have to take into account with
 2 Scotland is that they were in the process of changing
 3 the provision of routine vaccinations from primary care,
 4 from GP-led primary care, to vaccination centres. So
 5 then the vaccination centres, the pragmatic combination
 6 of offering flu and Covid in that autumn made sense.
 7 I do not necessarily think that that on its own
 8 supported reaching out to marginalised communities, and
 9 I think there was a definite kind of -- that health
 10 professionals in Scotland would have liked to have been
 11 able to do a more tailored provision.
 12 **Q.** Presumably, because there was a system of combined
 13 vaccination already up and running and the
 14 transformation was, to a significant extent, already
 15 done, and complete, there was a practical experience in
 16 the system already operating? I suppose that's what you
 17 would note?
 18 **DR CHANTLER:** In parts of Scotland, but not in all parts,
 19 and I think some of the Scottish Health Boards,
 20 particularly in some of the more rural, dispersed areas
 21 were still running quite a lot of vaccinations through
 22 GP surgeries and through additional outreach.
 23 **Q.** You refer, as it happens, to the fact that Public Health
 24 Scotland in 2020 had conducted a health inequalities
 25 impact assessment, this is page 38, paragraph 123. Do
 180

1 you think that that process, that inquiry, or that
 2 review, assisted with the delivery of vaccines to --
 3 **DR CHANTLER:** Yes.
 4 **Q.** -- people suffering from inequalities?
 5 **DR CHANTLER:** Yes, I think that would have definitely
 6 helped --
 7 **Q.** And is that because it highlighted the issue? It really
 8 put it up in lights that there was an issue that had to
 9 be tackled? Is that how it worked?
 10 **DR CHANTLER:** Well, it comes back to these things have to be
 11 spoken, documented, and then funding and resources needs
 12 to be allocated to actually address it. And I think
 13 this comes back to what we were talking about, the
 14 accountability and kind of recognising where the
 15 barriers are and then thinking about how do you address
 16 it. So ...
 17 **Q.** On page 39 you deal with a different aspect of delivery
 18 in Scotland, which was the delivery of Pfizer vaccines
 19 into care homes in September 2020, and you note that
 20 Scotland initiate a policy of vaccinating care home
 21 staff on the same visit as residents.
 22 Was that something that Scotland did differently,
 23 was that not in place for other countries, or -- or were
 24 they an outlier in that regard?
 25 **DR CHANTLER:** They were an outlier, and -- as far as we're
 181

1 forward for, you know, vaccine equity committees or
 2 accountability groups across the system.
 3 **Q.** And in Wales also, the health boards have a high degree
 4 of integration of primary and community health services
 5 and secondary and tertiary care, so they have perhaps
 6 a better understanding across the whole range and
 7 breadth of the healthcare services being provided in
 8 a particular region?
 9 **DR CHANTLER:** Yeah. And I think this comes back to a word
 10 we do use in this report a lot, it's about this "place
 11 based", when you think about how to best provide
 12 immunisation services within a geographical area,
 13 knowing the population, understanding the social and
 14 healthcare services. So if you've already got a health
 15 board that has representation of all those groups and
 16 regularly talks, that's only going to be a bonus.
 17 **Q.** And in Wales also, was there a Vaccine Equity Committee,
 18 of which we've heard something in evidence; this -- the
 19 presence or existence of a committee specifically
 20 dealing with equities is of value, is it not?
 21 **DR CHANTLER:** Yes.
 22 **Q.** And were there also -- I think there were also equity
 23 committees in Scotland and in Northern Ireland.
 24 **DR CHANTLER:** Yes.
 25 **Q.** But perhaps not a self-standing equity committee in
 183

1 aware. And I think this a key learning to take forward
 2 and to think about, and we touched on this already with
 3 the carers question earlier, to actually making sure
 4 that there's a clear offer and that carers know where
 5 they can be vaccinated.
 6 **Q.** In Wales -- page 41, please -- a Wales Covid-19
 7 Vaccination Board was developed, as we've heard in
 8 evidence during the course of today, and the Covid-19
 9 vaccination board had representatives from the seven
 10 Welsh health boards on it, and those Welsh health boards
 11 had representation from public health directors.
 12 **DR CHANTLER:** Mm-hm.
 13 **Q.** Do you conclude that that process by which directors of
 14 public health were brought closer into the integrated
 15 approach to health assisted?
 16 **DR CHANTLER:** It definitely assisted, I think, and was
 17 supported by the decentralisation and allowed, I think,
 18 Wales also to do very much a decentralisation approach.
 19 In England, and I was involved in one of the evaluations
 20 we reference, we found that when regions were developing
 21 their vaccine inequalities committees, that's when you
 22 got the DRPHs talking to the NHS England strategic
 23 officers or the -- you know, their area officers. So
 24 that had to be created, whereas this existed already.
 25 So I think again, this is key learning as we think
 182

1 England. But you'll correct me if I'm wrong.
 2 **DR CHANTLER:** I think there were vaccine equity committees,
 3 and particularly regional levels, and they were created
 4 over time, again with input from directors of public
 5 health.
 6 **Q.** But perhaps less prominent than the --
 7 **DR CHANTLER:** Yes.
 8 **Q.** -- analogue from Wales and Scotland?
 9 **DR CHANTLER:** But they will have come into Wales during the
 10 Covid pandemic, yes.
 11 **Q.** Picking up the threads of your conclusions at pages 43
 12 to 45, firstly, do you make the point that operational
 13 flexibility is vital in order to ensure that
 14 a prioritisation strategy is applied as fairly and as
 15 widely as can reasonably be made to work?
 16 **DR CHANTLER:** Yeah, we would agree. And I think it's about
 17 that balance of pace but also providing equitable
 18 services.
 19 **Q.** And in terms of the structures in place, the more that
 20 can be done to focus on bodies focusing on equities, or
 21 lack of equity, and the more that healthcare providers
 22 can have a proper understanding of their local or
 23 regional area by way of integrating care, health and
 24 possibly routine immunisation, the better, because it
 25 all adds to the general degree of knowledge and
 184

1 experience?

2 **DR CHANTLER:** Yes, can only agree.

3 **Q.** All right. And then we turn, please, to -- in fact

4 I should have actually asked you, Dr Kasstan-Dabush, is

5 there anything on the conclusions that you want to add?

6 This was an area that you were particularly focusing on.

7 **DR KASSTAN-DABUSH:** No, I think Tracey covered all the key

8 points.

9 **Q.** All right.

10 You provide a number of charts and a fair amount of

11 statistics demonstrating the level of coverage across

12 all four nations. They are what they are, and we've

13 heard a fair amount about the levels of take-up, so

14 we're just going to highlight, please, Dr Chantler, how

15 you've provided charts divided by sectoral area or age

16 or geographical location.

17 Page 47, do you provide a chart showing people who

18 received at least one dose of Covid-19 across each

19 country?

20 **DR CHANTLER:** Yes, we do.

21 Just to note, is that this is based on the whole

22 population and not necessarily the eligible population,

23 this chart.

24 **Q.** So it's divided by the total population --

25 **DR CHANTLER:** Mm-hm.

185

1 paragraph 179. The headline point is, and the tribunal

2 has already received considerable evidence on this, in

3 England:

4 "Ethnic minority groups ... had lower

5 age-standardised rates of vaccination coverage compared

6 with ... White British ... Covid-19 vaccine uptake

7 varied by ethnicity in upper age priority cohorts ..."

8 But:

9 "Among adults aged 80+ who received two ... doses,

10 people of Black African and Black Caribbean

11 ethnicities ... had lower-levels of uptake compared

12 to ... White British ..."

13 Then you go on and give details of take-up rates

14 amongst black African people, and Indian ethnic groups.

15 And over the page, how adults aged 50 and over who

16 received two doses, adults of black Caribbean

17 ethnicities were consistently the least vaccinated

18 minority.

19 By June 2022, however, had people of black African

20 ethnicities reached the 75% threshold that was used as

21 the font for the planning assumptions which were

22 applied, at least by the UK Government?

23 **DR CHANTLER:** So just to note here, we will be submitting

24 a correction, because there was some additional data

25 that was in a previous chart that's been removed.

187

1 **Q.** -- rather than, for example over-18s or over-12s or

2 something like that?

3 **DR CHANTLER:** It's just that under-5s were not offered the

4 vaccination, so there could be a slight bias in the

5 figures.

6 **Q.** And it's only up to September 2021 and it's at least one

7 vaccine dose rather than two --

8 **DR CHANTLER:** Yeah.

9 **Q.** -- or a third and a booster.

10 Page 49, you produce a chart showing percentage of

11 adults receiving two vaccinations segregated by age.

12 And as is absolutely obvious, self-evident, the more

13 elderly in our population had a much higher take-up than

14 the younger cohorts; correct?

15 **DR CHANTLER:** Correct.

16 **Q.** Page 51, there's a chart going showing

17 under-vaccination, and, by and large, was there

18 a greater proportion of under-vaccinated people in

19 younger age groups, as might be expected?

20 **DR CHANTLER:** Yes.

21 **Q.** Then on page 52 there is a chart showing vaccination by

22 age. I don't think we need to dwell on that. There's

23 a chart on page 54, take-up by sex. And then on page 55

24 you turn to ethnicities.

25 And can we just look, please, at page 55 and

186

1 So by June 2022 in England, 81.7% of black African

2 adults aged over 50 had received two Covid vaccines. So

3 yes, they reached that threshold of 75%. However, it

4 was lower in black Caribbean groups of over-fifties.

5 And it was lower in black African over 18 -- and over

6 18 years old(?).

7 I think also the point I just want to reiterate, and

8 I know we've covered it already, is I think to us we

9 were extremely concerned that the black Caribbean and

10 black African people over-80 people had such a low

11 uptake that didn't catch up as quickly as in other

12 ethnicities, given that they were priority group 2, and

13 I think this is a really important thing for us to take

14 on as learning moving on. And I know you've covered

15 that in other modules as well.

16 **Q.** Is this the point that the over 80-year-olds were, of

17 course, most at risk --

18 **DR CHANTLER:** Mm.

19 **Q.** -- and therefore, if you have a significant proportion

20 of over 80-year-olds in any particular ethnic minority

21 group who aren't reaching the same level of take-up as

22 other over 80-year-olds, there's a major public health

23 concern there?

24 **DR CHANTLER:** Yeah, a major issue for mortality, morbidity,

25 and the fact that these groups were not vaccinated was

188

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

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

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

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

189

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

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

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

19 **DR CHANTLER:** Mm.

20 **Q.** All right.

21 We can then move forward, please, to data.

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

25 It's obvious from the data that you've been able to

191

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

2 **DR KASSTAN-DABUSH:** Sorry?

3 **Q.** That has obviously riled you, my question?

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

7 **Q.** All right, thank you very much.

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

14 **DR CHANTLER:** Yes.

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

18 **DR CHANTLER:** Yes.

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

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

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

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

190

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

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

20 And that allowed to have kind of ideas of coverage.

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

192

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

6 **DR KASSTAN-DABUSH:** Yeah.

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

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

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

25 **DR KASSTAN-DABUSH:** Mm-hm.
193

1 Q. If it can be done.

2 **DR KASSTAN-DABUSH:** (Witness nodded).

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

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

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

195

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

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

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

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

194

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

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

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

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

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

196

1 **Q.** I'll come to that, I'll come to Dr Kasstan-Dabush's
2 views in a moment.
3 Dr Chantler, this a highly complex field.
4 Presumably issues of distrust and lack of trust in
5 government and in vaccines and in delivery programmes is
6 also connected to other deep-seated issues concerning
7 misinformation and the reliability of information, in
8 the hands of all these prospective patients. So it's
9 a highly complex issue.

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

18 **DR CHANTLER:** Mm.

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

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

197

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

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

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

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

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

199

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

6 **DR CHANTLER:** Mm.

7 **Q.** I mean, that seems self-evident.

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

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

198

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

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

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

15 **DR CHANTLER:** Yes.

16 **Q.** That's the position. All right.

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

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

200

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

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

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

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

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

201

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

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

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

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

15 **Q.** Children.

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

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

25 Could I just in one further question just suggest

203

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

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

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

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

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

25 **DR KASSTAN-DABUSH:** Mm.
202

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

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

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

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

16 **MR KEITH:** Thank you.

17 **LADY HALLETT:** Thank you.
18 Mr Weatherby.

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

20 **LADY HALLETT:** Oh, thank you very much, Mr Weatherby.
21 Who is next? Mr Wagner, who is that way.

Questions from MR WAGNER

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

25 I ask questions on behalf of Clinically Vulnerable
204

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

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

19 **DR KASSTAN-DABUSH:** I think it's the identification,
 20 crucially, to who is that vulnerable cohort and the
 21 triaging them to the locations that make most sense, ie,
 22 not a mass vaccination centre, a primary care or an
 23 outreach site, for example, with quieter hours or hours
 24 for reduced footfall, longer appointment times,
 25 depending on the needs of the various groups you've
 205

1 **DR CHANTLER:** Yes.

2 Questions from MS BEATTIE

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

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

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

21 **DR KASSTAN-DABUSH:** And this is a heterogeneous cohort, of
 22 course, and an umbrella cohort, and there are groups who
 23 were higher risk and higher prioritisation than others.
 24 The question is, again, in the routine context: where
 25 should that information be stored, and stored in a way
 207

1 mentioned, I would say identification and triage.

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

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

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

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

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

19 **DR CHANTLER:** Yeah.

20 **Q.** And triage?

21 **DR CHANTLER:** Yeah.

22 **MR WAGNER:** Thank you.

23 **LADY HALLETT:** Thank you, Mr Wagner.

24 Ms Beattie.

25 Ms Beattie is over there. Can you see her?
 206

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

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

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

12 **Q.** Just to follow that up, I think is one of your
 13 recommendations that it is important to be able to
 14 accurately disaggregate data according to protected
 15 characteristics, such as disability status?

16 **DR KASSTAN-DABUSH:** Absolutely. In order to be able to
 17 offer that tailored approach for those who need it.
 18 Absolutely.

19 **MS BEATTIE:** Thank you, my Lady.

20 **LADY HALLETT:** Thank you very much, Ms Beattie.

21 Those are all the questions we have for you. Thank
 22 you very much indeed for your help preparing your
 23 report. As I said earlier, I promise I will make sure
 24 that all the material you put into your report is
 25 carefully considered. I'm really grateful to you for
 208

1 the work you did preparing that and, of course, your
 2 colleagues who help you, and thank you very much for
 3 your help today.

4 **DR CHANTLER:** Thank you.

5 **DR KASSTAN-DABUSH:** Thank you.

6 (The witnesses withdrew)

7 **LADY HALLETT:** Very well. 10.00 tomorrow, please.

8 **(4.28 pm)**

9 **(the hearing adjourned until 10.00 am the following day)**

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11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

INDEX

1
2
3 MR DEREK GRIEVE (sworn) 1
4 Questions from LEAD COUNSEL TO THE INQUIRY ... 1
5 FOR MODULE 4
6 Questions from DR MITCHELL KC 57
7
8 PROFESSOR DR GILLIAN RICHARDSON 63
9 (affirmed)
10 Questions from COUNSEL TO THE INQUIRY 63
11 Questions from MR DAYLE 104
12
13 DR NARESH CHADA (affirmed) 107
14 Questions from COUNSEL TO THE INQUIRY 107
15 Questions from MR WILCOCK KC 133
16 Questions from MR WEAVER 137
17
18 DR BEN KASSTAN-DABUSH (affirmed) 142
19 DR TRACEY CHANTLER (sworn) 142
20 Questions from LEAD COUNSEL TO THE INQUIRY 142
21 FOR MODULE 4
22 Questions from MR WAGNER 204
23 Questions from MS BEATTIE 207
24
25

DR CHANTLER: [86] 142/24 143/12 144/12 144/17 144/23 145/6 146/13 147/1 147/15 147/24 148/25 149/7 149/13 149/18 150/8 150/14 151/1 151/15 152/7 152/15 153/19 154/17 156/24 168/2 169/6 169/20 170/25 171/5 171/7 172/11 173/8 173/16 174/14 175/11 176/18 178/11 179/16 179/22 180/1 180/18 181/3 181/5 181/10 181/25 182/12 182/16 183/9 183/21 183/24 184/2 184/7 184/9 184/16 185/2 185/20 185/25 186/3 186/8 186/15 186/20 187/23 188/18 188/24 189/14 190/14 190/18 190/21 190/25 191/7 191/19 195/14 196/7 197/18 197/22 198/6 198/8 199/18 200/1 200/15 200/17 201/21 206/9 206/19 206/21 207/1 209/4 DR KASSTAN-DABUSH: [54] 142/22 143/10 143/21 144/6 155/4 156/5 156/23 157/17 157/22 158/14 158/23 159/14 159/19 159/21 160/14 161/23 162/11 163/2 163/8 163/13 164/4 164/7 164/12 166/2 166/9 166/13 167/14 167/18 167/20 170/9 177/10 177/20 185/7 189/23 190/2 190/4 192/6 193/6 193/13 193/25 194/12 194/23 195/2 202/13 202/25 203/13 204/9 204/14 205/19 206/4 207/21 208/10 208/16 209/5 DR MITCHELL: [2] 57/23 62/22 LADY HALLETT: [47] 1/3 9/21 9/24 10/2 14/12 14/14 57/16 57/19 57/21 62/24 63/8 63/13 63/19 91/17 91/23 92/2 104/17 106/18 106/23 107/2 107/6 107/10 107/15 131/10	131/13 131/16 132/24 136/14 137/10 137/12 141/10 141/16 141/20 141/23 142/2 142/6 142/12 160/11 160/21 161/1 174/4 203/16 204/17 204/20 206/23 208/20 209/7 MR DAYLE: [2] 104/21 106/17 MR KEITH: [16] 1/4 1/8 9/23 9/25 10/3 14/13 14/15 57/18 57/20 142/13 142/20 160/20 161/2 174/22 203/23 204/16 MR WAGNER: [2] 204/23 206/22 MR WEATHERBY: [1] 204/19 MR WEAVER: [2] 137/17 141/8 MR WILCOCK: [5] 133/2 136/11 136/15 137/9 137/11 MS BEATTIE: [2] 207/3 208/19 MS STEPHENSON: [8] 63/14 63/21 92/4 104/16 107/11 107/17 131/19 132/23 THE WITNESS: [11] 63/6 63/20 106/22 107/1 107/4 141/15 141/19 141/22 141/25 142/3 142/10 ' 'individual [1] 172/22 'just [1] 79/21 1 1.45 [2] 107/6 107/9 1.8 [1] 58/22 10 [1] 41/24 10 January [1] 118/12 10-year [1] 75/9 10.00 [2] 1/2 209/7 10.00 am [1] 209/9 100 [4] 81/23 127/15 199/16 199/19 103 [1] 174/22 105 [2] 203/2 203/6 105 exhibits [1] 64/1 107 [1] 176/9 108 [1] 7/9 11 [9] 34/1 34/4 35/23 36/1 146/6 146/13 148/9 149/14 152/8 11 January [1] 83/7 11 January 2021 [1] 79/1	11.26 [1] 63/10 11.40 [2] 63/9 63/12 116 [1] 178/16 12 [5] 46/8 47/13 47/20 148/4 149/14 12.46 [1] 107/7 123 [1] 180/25 12s [1] 186/1 13 [3] 38/6 147/4 148/8 13:52:25 [1] 117/20 14 January one [1] 38/23 14.1 [1] 86/7 15 [2] 117/20 150/25 15 December [1] 13/20 15 December 2020 [1] 32/20 15-minute [4] 18/2 69/5 104/10 104/15 15-year-olds [3] 46/8 47/14 47/20 16 [3] 35/23 36/1 69/6 16 August 2024 [1] 63/25 16,000 [1] 82/14 179 [1] 187/1 18 [2] 152/8 188/5 18 years [1] 188/6 18s [1] 186/1 19 [35] 3/18 5/9 7/11 13/4 18/15 38/2 53/3 65/18 65/19 65/21 66/13 68/4 70/18 70/20 90/22 105/2 112/10 115/25 129/19 137/4 140/12 151/16 152/10 154/7 155/3 156/8 160/8 178/2 182/6 182/8 185/18 187/6 191/24 192/10 202/16 19.58 [1] 34/14 197 [1] 138/1 198 [1] 138/10 199 [2] 138/1 138/15 2 2.9 million [1] 18/7 20.49 [1] 34/5 20.55.05 [1] 32/21 2000s [1] 64/25 2001 [1] 108/9 2009 [2] 92/14 150/25 2017 [1] 65/4 2018 [1] 8/16 2019 [5] 1/18 65/8 75/15 108/9 108/11 2020 [22] 2/18 3/19 4/21 4/24 5/1 5/5 5/5 17/11 32/20 65/21	70/14 76/14 88/3 88/4 108/15 108/15 109/4 115/24 149/24 150/10 180/24 181/19 2021 [27] 1/19 4/16 17/12 20/2 20/3 21/10 28/24 30/11 34/1 38/6 44/17 45/14 51/13 58/22 66/15 66/25 70/19 70/24 79/1 85/16 88/1 98/19 117/16 121/19 121/24 179/19 186/6 2022 [2] 187/19 188/1 2024 [3] 1/13 63/25 107/22 2025 [1] 1/1 21 [2] 148/8 161/4 22 [1] 162/24 22 March 2021 [1] 88/1 22.7 [1] 75/11 23 [1] 164/1 237 [1] 105/8 24 [1] 9/6 24 February [1] 96/16 24 hours [3] 19/12 19/20 96/6 24 June [1] 99/4 250 [2] 81/24 205/10 26 [2] 75/10 165/18 26 January [1] 82/10 27 [1] 165/18 28 January 2025 [1] 1/1 28 October 2024 [1] 107/22 3 3.03 [1] 160/23 3.20 [2] 160/21 160/25 3.375 million [1] 39/12 30 [3] 84/23 168/24 169/5 30 different [1] 201/10 300 [1] 82/10 31 January [1] 36/20 32 [2] 170/14 171/1 33 [2] 82/11 174/22 34 [2] 55/24 176/9 36 [1] 177/25 37 [1] 179/17 370 [1] 203/7 38 [2] 82/11 180/25 387 [1] 82/10 39 [1] 181/17 4 4.28 [1] 209/8	41 [2] 36/1 182/6 43 [3] 7/4 7/7 184/11 45 [1] 184/12 47 [1] 185/17 49 [2] 101/4 186/10 5 50 [4] 94/14 94/20 187/15 188/2 51 [1] 186/16 52 [2] 82/11 186/21 54 [1] 186/23 55 [2] 186/23 186/25 55 pages [1] 107/23 5s [1] 186/3 6 6 hours [1] 81/3 6,000 [1] 127/21 65 [1] 126/15 66 pages [1] 64/1 69-year-old [1] 126/16 690,000 [1] 41/12 7 7.5 [1] 75/14 75 [2] 187/20 188/3 8 8 December [3] 128/23 159/25 172/5 8 January [1] 77/13 8 March 2021 [1] 51/13 8 o'clock [2] 34/17 58/12 8.28 [2] 22/24 23/17 80 [6] 10/18 14/17 99/7 123/19 187/9 188/10 80 year [1] 13/9 80-year-olds [5] 14/25 15/3 188/16 188/20 188/22 80s [1] 86/7 81.7 [1] 188/1 86.5 [1] 99/5 89 [2] 99/9 200/24 9 90 onwards [1] 200/24 92.5 [1] 99/4 94 [2] 99/10 201/5 95 [3] 168/24 169/5 199/20 950 [1] 13/12 97 [1] 200/3 975 doses [1] 14/7 98 [2] 99/10 169/13 98% on [1] 75/20 99 [1] 205/3 99b [1] 170/17
--	---	---	---	---

9	162/15 166/5 170/5 171/8 171/19 173/10 174/6 174/8 174/8 175/12 175/13 175/22 176/25 178/23 181/13 181/15 182/2 183/10 183/11 184/16 185/13 189/15 189/24 192/3 193/7 194/4 196/8 199/14 199/25 200/18 201/23 205/1 205/11 206/15 206/18 207/15 207/17 208/4 about 5 [1] 58/20 above [2] 94/15 171/2 abroad [2] 66/24 144/21 absence [4] 26/12 41/25 65/10 154/25 absolutely [24] 7/24 26/6 42/6 44/15 61/4 69/23 78/22 81/8 81/11 106/22 114/25 115/25 123/1 127/22 155/4 156/7 157/22 158/14 159/19 186/12 194/23 208/11 208/16 208/18 academic [2] 26/18 27/5 accept [3] 101/9 105/1 114/18 accepted [2] 75/24 104/9 access [22] 22/24 50/18 56/14 56/16 68/8 92/11 93/13 94/5 113/18 144/5 153/17 156/2 170/19 175/19 178/12 195/7 195/8 195/16 197/13 197/14 201/13 206/16 accessibility [2] 52/4 205/2 accessible [4] 52/10 87/7 89/5 101/15 accommodate [2] 93/12 94/6 accommodation [1] 90/10 according [4] 74/23 113/18 114/16 208/14 account [4] 52/15 101/1 134/21 180/1 accountability [6] 146/17 177/12 177/17 181/14 183/2 189/24 accountable [2] 4/9 116/15 accurate [3] 33/12 122/6 208/6 accurately [1] 208/14 accusation [1] 35/25	accusations [3] 35/12 36/4 36/15 achieve [3] 72/16 86/18 100/5 achieved [6] 39/18 47/14 73/6 84/6 116/5 179/14 achieving [1] 72/14 Acknowledgement [1] 196/9 acknowledging [1] 196/4 acquisition [1] 119/7 acronym [1] 8/10 across [36] 12/15 29/18 30/4 61/10 73/1 78/17 111/16 112/7 114/15 122/16 132/21 145/12 147/18 150/24 151/17 153/2 155/9 155/13 157/3 158/8 160/17 162/16 163/18 164/13 168/18 172/5 183/2 183/6 185/11 185/18 191/17 191/24 194/14 194/18 196/19 208/1 act [8] 15/25 41/20 48/22 49/8 77/25 108/18 199/3 199/6 acting [3] 65/16 71/13 195/25 action [8] 57/11 72/21 88/20 88/24 160/10 196/3 196/9 202/9 actions [4] 51/13 51/21 71/8 88/4 active [3] 102/8 102/15 105/3 activities [1] 1/24 activity [15] 8/14 12/2 17/23 18/9 18/22 19/1 22/3 22/4 29/3 43/20 49/21 62/9 62/14 62/16 82/21 actors [1] 146/15 actual [7] 18/13 102/9 116/8 120/5 134/14 198/11 199/10 actually [43] 11/14 13/21 27/5 42/19 77/19 78/3 84/25 85/12 85/14 88/23 91/15 94/4 94/21 95/5 98/25 99/3 99/9 110/20 117/10 119/24 120/7 125/6 136/13 139/16 145/18 145/25 146/25 153/11 153/15 175/8 175/15 181/12 182/3 185/4 189/15 189/19 196/18 197/23 198/14 198/15 198/24	199/15 202/8 acute [1] 93/9 adapt [1] 83/4 adapted [4] 20/15 42/18 48/1 136/10 add [6] 89/10 170/9 177/9 185/5 196/24 202/12 added [2] 20/1 20/17 additional [6] 152/16 152/18 156/21 171/10 180/22 187/24 additionally [1] 159/7 address [19] 91/16 131/24 144/4 145/19 146/7 152/18 159/2 162/17 170/15 176/10 176/21 181/12 181/15 190/5 196/1 196/11 199/6 199/9 204/10 addressed [4] 50/10 73/23 156/3 196/17 addressing [9] 50/18 50/24 51/10 158/12 158/12 176/19 195/15 198/4 202/11 adds [1] 184/25 adjourned [1] 209/9 Adjournment [1] 107/8 adjust [1] 22/1 adjusted [1] 75/13 administered [3] 16/4 42/25 192/13 administration [2] 148/13 178/13 administrations [22] 27/16 28/17 31/21 33/13 36/12 36/23 37/6 109/23 114/1 114/18 115/13 118/16 119/11 119/16 122/17 151/18 151/24 153/2 155/8 172/21 179/1 192/11 administrative [3] 11/15 29/10 177/19 adolescent [1] 168/8 adopted [6] 13/14 14/1 40/15 81/14 97/1 155/2 adult [3] 76/7 83/4 129/4 adults [6] 86/17 186/11 187/9 187/15 187/16 188/2 advance [2] 18/24 42/7 advantage [2] 125/6 125/19 advantages [2] 12/7 98/20 adverse [1] 140/8 advice [28] 16/25	17/21 19/6 25/21 38/10 40/19 40/19 41/10 46/24 51/6 69/10 73/10 74/12 74/12 94/10 95/16 95/17 97/11 97/13 104/6 106/7 106/11 138/13 141/2 141/3 141/6 165/11 165/12 advise [2] 97/6 163/23 advised [1] 55/4 adviser [1] 65/17 advises [1] 99/7 advising [1] 109/13 Advisor [1] 120/14 advisory [4] 69/9 74/9 95/24 97/6 advocating [1] 168/3 affairs [1] 146/11 affect [1] 105/21 affected [4] 122/23 141/24 141/25 142/3 affirm [1] 108/2 affirmed [6] 63/17 107/13 142/17 210/9 210/13 210/18 afforded [2] 28/16 77/2 afraid [2] 38/22 136/21 Africa [1] 66/24 African [12] 54/20 105/11 187/10 187/14 187/19 188/1 188/5 188/10 189/18 190/12 196/16 198/13 after [10] 3/13 82/9 88/9 96/5 124/18 135/11 137/22 138/20 143/8 175/24 afternoon [4] 133/2 137/18 142/14 207/7 afterwards [1] 141/7 again [22] 35/1 52/3 97/24 126/5 144/9 159/3 159/9 159/21 160/8 162/15 163/13 163/19 164/14 164/22 165/3 167/20 170/12 172/17 182/25 184/4 198/14 207/24 against [6] 20/14 39/18 131/9 135/25 163/13 194/13 age [30] 21/12 44/22 44/22 46/3 60/15 66/9 69/15 69/20 75/5 75/6 75/9 83/15 123/19 126/16 129/14 145/16 154/12 157/9 157/14 160/2 160/9 160/19 185/15 186/11 186/19 186/22 187/5 187/7
----------	---	--	--	--

A	33/18 33/21 34/12 34/22 38/20 39/12 40/5 41/6 41/11 42/4 44/15 48/20 50/16 51/9 51/17 52/7 53/20 57/5 58/4 58/7 58/20 59/15 60/6 61/8 61/10 63/20 64/12 66/11 66/11 68/5 69/25 73/6 73/7 75/13 78/2 80/9 82/14 82/21 84/13 88/2 88/19 90/12 91/14 92/12 92/25 95/11 96/11 106/23 109/20 114/8 117/7 117/11 117/16 121/17 128/5 128/20 130/7 131/13 131/20 134/18 135/6 138/4 139/7 141/16 141/20 145/7 145/9 156/22 159/20 163/18 168/15 169/9 170/8 173/9 174/15 175/12 177/25 180/18 183/15 184/25 185/3 185/7 185/9 185/12 190/7 190/11 190/15 190/25 191/1 191/16 191/20 192/17 197/8 198/2 200/5 200/7 200/13 200/16 204/15 208/21 208/24	already [31] 5/1 9/14 22/6 27/20 27/23 40/23 47/5 54/24 56/9 82/4 113/23 145/22 145/24 151/3 154/18 154/19 168/6 175/21 180/13 180/14 180/16 182/2 182/24 183/14 187/2 188/8 195/20 198/23 199/2 203/20 207/7	205/4 am [7] 1/2 35/23 36/1 63/10 63/12 100/19 209/9 ambition [1] 90/6 ambulance [3] 45/15 45/24 82/15 amend [1] 31/25 amended [1] 95/20 among [4] 143/18 155/14 187/9 192/22 amongst [10] 21/21 47/13 90/17 100/6 104/25 130/19 187/14 190/16 195/11 203/10 amount [12] 10/23 11/3 14/8 19/12 25/13 35/4 66/20 80/25 134/18 185/10 185/13 199/9 amounts [1] 173/22 analogue [1] 184/8 analyse [1] 203/22 analysed [3] 140/20 141/1 203/20 analysis [1] 141/6 analytical [1] 141/1 analytics [1] 129/11 anaphylactic [1] 69/7 Andrew [1] 71/12 anecdotal [1] 59/1 Anglo [1] 78/17 Anglo-centric [1] 78/17 Anne [1] 73/14 announce [2] 18/25 34/15 announced [1] 25/21 announcement [4] 34/17 34/19 34/20 34/22 announcements [1] 120/25 annual [1] 97/21 anonymised [1] 194/6 another [12] 3/22 23/5 26/25 41/8 61/7 95/13 131/17 154/16 155/18 156/4 161/2 199/15 answer [5] 136/2 136/11 136/13 137/14 143/8 anti [1] 98/25 anti-vax [1] 98/25 anticipate [1] 106/15 anticipated [4] 19/23 24/13 39/20 105/3 Anwar [1] 57/23 any [35] 15/16 19/17 22/24 25/9 34/21 38/12 46/23 53/21 56/22 60/2 60/21	61/24 66/2 69/12 72/25 73/5 75/25 78/18 83/10 87/3 95/5 96/22 99/16 100/23 104/9 112/19 115/2 131/22 138/13 142/7 158/20 188/20 191/4 196/8 199/8 anybody [3] 98/4 98/6 153/12 anything [4] 103/17 168/1 177/9 185/5 anyway [2] 16/10 142/9 apologies [2] 8/21 107/15 app [1] 102/21 apparent [1] 152/17 apparently [1] 37/2 appear [6] 56/5 136/20 161/16 173/2 175/5 179/12 appeared [1] 26/4 appears [4] 24/14 28/1 161/7 194/20 Appleby [1] 32/10 applicable [2] 121/16 157/2 applied [3] 138/8 184/14 187/22 apply [3] 87/9 89/20 91/8 applying [1] 157/13 appointed [3] 108/9 108/23 110/7 appointment [11] 42/21 55/23 55/23 56/25 60/8 60/9 60/13 66/15 66/16 95/12 205/24 appointments [7] 82/17 82/20 93/20 94/22 95/9 96/15 126/15 apportion [1] 23/24 apportioned [1] 30/15 appreciate [3] 78/15 88/5 134/14 appreciation [1] 18/18 approach [65] 5/16 5/18 6/1 8/4 13/14 14/1 16/19 24/8 33/20 37/21 47/1 47/21 47/21 49/10 51/8 54/15 60/4 61/9 71/19 95/20 96/18 97/1 97/25 98/20 123/22 126/2 126/3 126/3 126/9 126/17 133/24 136/17 136/19 147/20 147/25 154/15 154/23 155/10 156/10 156/10
----------	---	--	---	--

<p>A</p> <p>approach... [25] 156/13 157/4 157/14 157/16 157/19 157/21 158/7 158/13 158/16 158/21 160/9 162/16 163/19 165/1 165/7 167/11 168/4 168/20 178/15 178/15 179/18 182/15 182/18 203/8 208/17</p> <p>approaches [6] 78/9 155/13 155/18 156/6 160/7 162/4</p> <p>approaching [2] 75/22 76/1</p> <p>appropriate [9] 69/20 141/2 141/6 157/13 158/13 160/10 162/20 163/25 177/7</p> <p>appropriately [1] 158/21</p> <p>approval [3] 45/15 68/19 80/7</p> <p>approved [5] 109/2 123/4 123/15 138/6 139/4</p> <p>approximately [2] 35/23 127/20</p> <p>April [2] 66/25 108/11</p> <p>April 2019 [1] 108/11</p> <p>April 2021 [1] 66/25</p> <p>are [122] 7/13 7/16 9/21 9/24 12/9 12/24 13/8 13/10 14/17 22/22 30/10 42/8 46/6 52/10 57/16 62/23 64/4 71/4 74/25 75/6 79/8 79/21 82/17 85/24 87/3 87/3 87/4 90/25 91/6 91/11 91/15 91/19 91/20 99/18 99/24 99/25 100/17 102/11 102/13 104/16 106/15 106/16 108/1 111/14 112/24 113/25 114/18 116/4 123/9 128/15 128/20 129/12 130/9 131/22 132/11 132/11 132/23 136/4 136/6 136/23 137/2 138/7 138/16 138/20 139/4 139/17 140/25 142/14 143/7 143/13 144/8 144/13 149/25 150/16 153/19 153/21 159/15 161/20 161/24 162/12 166/14 166/16 166/17 166/20 167/2 167/21 169/7 170/6 171/15 171/20 172/21 172/25 176/20</p>	<p>181/15 185/12 185/12 189/6 189/17 191/7 191/9 191/15 191/15 191/17 193/14 193/14 194/23 195/18 196/15 196/19 197/20 198/9 198/10 198/15 199/14 200/6 201/25 204/3 204/12 206/15 207/22 208/9 208/21</p> <p>area [18] 12/2 44/2 45/12 45/13 51/19 62/11 72/11 73/24 93/4 95/13 129/14 129/20 182/23 183/12 184/23 185/6 185/15 195/4</p> <p>areas [42] 1/25 10/14 12/16 43/21 45/3 45/4 45/10 45/17 46/5 56/1 58/14 60/2 62/19 70/5 71/3 76/8 76/9 79/9 79/10 81/7 83/13 83/21 88/16 93/25 99/12 109/12 117/7 131/6 132/4 154/11 158/15 158/18 174/1 176/1 180/20 191/3 191/5 191/11 193/4 198/25 201/22 204/2</p> <p>aren't [4] 188/21 189/6 192/23 206/7</p> <p>Arena [1] 127/13</p> <p>arenas [1] 127/12</p> <p>arguments [1] 135/14</p> <p>arise [2] 60/4 91/15</p> <p>arises [1] 133/17</p> <p>arising [2] 161/2 205/14</p> <p>arm [1] 70/11</p> <p>arms [1] 95/6</p> <p>arose [4] 31/8 72/20 77/8 78/20</p> <p>around [21] 11/4 13/17 30/8 32/22 41/12 79/18 97/2 105/4 106/21 109/6 109/21 110/5 118/20 120/11 120/16 140/14 141/4 151/19 162/12 166/18 167/24</p> <p>arrangement [2] 14/4 21/9</p> <p>arrangements [5] 15/4 20/13 53/8 53/12 169/16</p> <p>arranging [1] 168/22</p> <p>arrived [1] 92/19</p> <p>arrives [2] 79/22 95/7</p> <p>as [304]</p> <p>ascending [1] 160/19</p> <p>Asian [3] 86/9 105/11 105/20</p>	<p>aside [1] 37/5</p> <p>ask [15] 46/7 56/17 77/3 89/11 92/5 93/14 121/11 133/17 153/8 157/12 167/1 174/4 204/25 205/1 207/3</p> <p>asked [9] 3/17 3/20 3/23 34/14 42/21 72/22 96/11 141/23 185/4</p> <p>asking [8] 1/14 34/23 36/7 37/19 59/12 62/17 102/4 133/4</p> <p>asks [1] 199/13</p> <p>aspect [4] 28/3 78/12 181/17 207/11</p> <p>aspects [9] 6/23 37/25 71/14 72/7 112/14 125/22 130/24 147/16 149/5</p> <p>assembly [1] 194/8</p> <p>assess [5] 13/17 43/2 54/1 150/22 178/7</p> <p>assessing [1] 164/24</p> <p>assessment [3] 13/7 175/6 180/25</p> <p>asset [1] 194/25</p> <p>assets [7] 9/15 113/7 125/11 125/17 125/18 126/19 127/14</p> <p>assist [11] 45/16 49/5 55/16 63/23 72/8 107/19 121/12 144/22 173/13 179/23 196/5</p> <p>assistance [4] 21/18 56/12 148/24 203/22</p> <p>assistant [1] 143/13</p> <p>assistants [1] 170/22</p> <p>assisted [4] 144/24 181/2 182/15 182/16</p> <p>associate [1] 144/8</p> <p>associated [3] 10/24 144/1 152/14</p> <p>Association [1] 173/11</p> <p>assume [1] 58/19</p> <p>assuming [1] 152/25</p> <p>assumption [1] 35/3</p> <p>assumptions [1] 187/21</p> <p>assurance [2] 4/12 42/19</p> <p>assurances [1] 140/6</p> <p>assure [1] 99/16</p> <p>assured [1] 91/3</p> <p>AstraZeneca [5] 21/12 69/16 69/19 123/14 124/5</p> <p>asylum [1] 91/20</p> <p>at [232]</p> <p>at page 55 [1] 186/25</p> <p>at: [1] 154/19</p> <p>at: how [1] 154/19</p>	<p>attempt [2] 88/24 134/19</p> <p>attempted [1] 136/25</p> <p>attempting [1] 42/5</p> <p>attend [2] 61/15 67/6</p> <p>attended [1] 90/4</p> <p>attending [8] 1/11 47/23 62/1 62/4 63/23 93/6 107/19 205/11</p> <p>attends [1] 27/15</p> <p>attention [3] 175/8 201/20 204/2</p> <p>attitudes [1] 85/23</p> <p>attractions [1] 157/19</p> <p>attributed [2] 30/17 36/9</p> <p>attuned [3] 126/11 130/20 130/21</p> <p>Audit [1] 71/1</p> <p>Auditor [1] 70/25</p> <p>August [3] 1/19 26/20 63/25</p> <p>August 2021 [1] 1/19</p> <p>austerity [1] 198/18</p> <p>Australia [1] 47/5</p> <p>authorisation [1] 104/12</p> <p>authorised [2] 38/13 124/9</p> <p>authorities [9] 71/17 89/13 96/19 96/21 105/12 105/20 113/13 153/24 161/14</p> <p>authority [6] 11/24 43/23 96/9 111/11 129/22 162/22</p> <p>autism [1] 93/24</p> <p>autumn [2] 17/19 180/6</p> <p>autumn-winter [1] 17/19</p> <p>availability [5] 23/21 28/6 48/9 192/6 205/2</p> <p>available [14] 21/11 23/13 48/9 89/3 95/9 103/22 118/7 120/24 121/10 152/19 153/2 153/25 156/8 207/16</p> <p>average [1] 75/15</p> <p>avoid [3] 61/11 94/23 138/13</p> <p>aware [16] 22/18 46/9 58/10 60/22 61/16 61/19 61/21 102/12 108/25 113/23 133/12 140/10 149/20 170/2 172/6 182/1</p> <p>awareness [1] 102/3</p> <p>away [2] 149/5 177/3</p> <p>awful [2] 110/18 174/7</p>	<p>B</p> <p>baby [1] 91/25</p> <p>back [25] 7/7 9/6 9/21 9/24 24/10 26/19 45/9 60/18 69/9 74/6 79/9 118/1 128/8 131/21 137/13 140/21 175/11 178/11 181/10 181/13 183/9 189/23 199/21 201/23 206/11</p> <p>background [8] 64/7 64/21 64/22 85/15 105/15 108/4 108/4 108/12</p> <p>backgrounds [1] 106/6</p> <p>bad [2] 4/24 142/5</p> <p>badly [1] 141/25</p> <p>balance [2] 59/14 184/17</p> <p>balanced [1] 46/25</p> <p>ball [1] 155/21</p> <p>bands [3] 75/6 75/6 75/9</p> <p>bank [1] 49/18</p> <p>Barnett [10] 22/21 23/10 23/10 30/15 74/19 75/2 113/16 113/22 113/24 152/25</p> <p>barrier [1] 89/15</p> <p>barriers [14] 50/18 54/3 54/5 132/12 144/5 153/17 156/2 175/4 181/15 195/6 195/15 196/12 197/13 205/1</p> <p>base [2] 23/8 74/6</p> <p>based [29] 35/4 47/1 47/4 47/20 47/21 51/8 66/9 75/2 86/19 105/12 106/2 106/16 113/10 113/16 115/23 123/22 125/12 126/7 135/15 164/15 165/22 166/12 167/10 167/10 167/20 178/8 183/11 185/21 200/6</p> <p>basically [26] 66/12 70/12 80/12 83/1 87/8 92/1 96/7 109/7 110/21 112/12 112/24 113/2 113/9 113/11 117/13 123/21 124/15 124/20 126/5 126/14 126/17 126/21 127/18 128/5 131/3 135/16</p> <p>basis [10] 31/5 55/12 65/9 74/19 90/5 120/21 133/9 133/11 157/13 194/22</p> <p>bat [1] 36/14</p> <p>batch [2] 24/12 80/6</p> <p>batches [1] 75/22</p>
---	---	---	---	--

B	96/10 102/10 102/22 104/14 105/3 109/12 111/22 114/2 114/10 116/2 117/22 118/17 119/10 123/3 123/11 129/3 129/13 129/17 130/14 136/11 138/3 140/4 145/22 150/7 150/15 151/25 152/25 159/10 159/15 161/8 161/16 161/25 168/12 168/13 172/7 174/7 175/5 180/10 187/25 189/2 191/25 195/21 198/18 199/12 201/16 205/17	believe [13] 55/4 56/1 74/1 74/2 78/18 90/2 90/18 101/9 135/13 136/9 138/3 140/3 201/16 believed [1] 55/17 believing [1] 33/6 Bell [2] 3/22 145/1 bells [2] 18/6 18/8 below [6] 69/6 84/25 116/19 116/22 126/14 176/12 below 16 [1] 69/6 Ben [7] 142/14 142/17 177/9 196/24 202/10 202/11 210/18 beneficial [2] 46/1 162/5 benefit [6] 42/12 78/8 96/19 150/24 179/5 200/14 benefits [6] 42/10 42/13 105/17 163/21 165/4 165/14 Benjamin [1] 142/22 Bereaved [7] 57/24 58/7 59/21 59/25 61/14 133/5 137/20 best [8] 51/25 57/16 71/5 88/23 118/1 163/23 167/14 183/11 better [27] 20/18 21/19 70/19 76/1 76/3 83/17 88/6 128/19 128/20 129/12 129/16 131/24 135/13 138/22 140/4 146/3 150/15 150/20 154/15 156/4 156/21 168/13 172/12 176/17 183/6 184/24 202/3 between [38] 2/8 2/18 6/10 17/11 18/12 18/14 19/6 22/22 24/4 32/16 59/14 59/25 60/5 75/7 76/13 76/17 77/8 80/17 86/2 86/8 94/24 97/4 105/19 114/20 115/4 115/6 115/8 115/10 117/16 125/9 126/6 145/14 145/21 148/10 152/3 191/2 191/10 198/12 beyond [1] 153/13 bias [1] 186/4 bible [1] 25/24 big [5] 45/24 111/19 130/14 130/24 131/11 biggest [2] 79/14 112/5 bilingually [1] 78/1 BioNTech [2] 123/5 124/2 bird's [1] 146/8	Birmingham [1] 76/9 bit [33] 6/8 8/19 8/22 15/5 15/7 15/9 24/7 28/10 30/3 32/2 41/8 43/22 44/10 44/14 47/7 53/2 112/4 112/18 114/12 114/16 118/18 118/24 128/3 132/10 132/18 139/12 139/23 140/18 144/15 149/1 173/20 175/21 190/21 bits [1] 33/18 black [23] 54/20 86/9 87/19 105/11 105/19 187/10 187/10 187/14 187/16 187/19 188/1 188/4 188/5 188/9 188/10 189/17 189/18 190/12 190/12 196/16 196/16 198/13 198/13 black African [1] 196/16 blended [4] 167/8 167/12 168/4 179/18 Blood [1] 64/16 blown [1] 142/4 blue [4] 56/19 57/6 57/9 57/14 board [61] 6/11 6/13 6/15 6/16 11/23 12/1 12/7 12/10 19/11 21/22 24/25 40/7 43/12 43/13 43/24 44/4 45/7 47/24 49/17 51/21 52/8 52/15 52/21 54/2 60/1 60/10 60/11 60/13 61/1 61/2 61/6 61/7 62/12 64/13 65/22 65/24 65/25 68/4 69/24 70/13 70/18 70/18 70/21 82/11 84/10 87/22 96/17 99/8 115/23 116/1 116/5 116/13 116/25 117/8 128/9 150/7 178/3 178/6 182/7 182/9 183/15 board's [2] 68/22 83/13 boards [62] 5/21 5/22 6/4 7/10 7/12 7/14 7/16 7/23 7/25 9/1 11/13 11/22 11/24 11/25 12/4 12/13 40/11 44/4 50/22 51/14 52/11 52/14 52/17 53/13 55/16 55/20 58/7 58/24 59/21 60/6 60/6 61/5 61/9 61/11 65/4 66/11 70/11 71/15 71/17 71/18 72/1 72/15 72/24 73/6 79/21 80/9	84/9 88/22 90/12 92/12 92/15 93/3 96/12 96/14 147/24 148/2 171/13 172/25 180/19 182/10 182/10 183/3 bodies [18] 7/5 9/18 50/17 52/25 106/11 141/1 148/5 148/11 148/13 148/13 148/17 149/10 152/4 152/5 168/22 176/10 184/20 201/18 body [3] 26/9 26/9 165/25 bold [1] 145/10 bonus [1] 183/16 book [8] 25/23 55/22 55/23 56/14 60/8 60/9 60/12 126/15 booking [3] 42/20 60/12 174/17 Boosted [1] 18/6 booster [2] 86/20 186/9 both [28] 4/20 11/23 17/24 22/1 40/21 45/8 50/6 54/1 74/12 74/16 74/16 88/8 111/5 115/14 119/6 120/8 121/4 123/11 124/5 126/19 142/20 143/8 144/25 154/24 167/10 168/14 176/23 205/16 bottom [1] 8/25 bowl [1] 155/21 box [1] 14/7 boxes [2] 16/1 173/4 breadth [2] 11/5 183/7 break [5] 15/25 53/2 63/11 160/24 175/4 breakneck [1] 48/19 breaks [1] 160/22 Bridgend [1] 92/25 brief [1] 75/2 briefed [2] 25/1 37/1 briefing [1] 98/19 briefly [4] 38/21 81/14 108/3 203/5 Brilliant [1] 57/17 bring [3] 38/2 125/18 135/2 brings [1] 203/1 Britain [1] 106/9 British [2] 187/6 187/12 broad [4] 29/17 29/21 155/8 169/16 broadened [1] 161/10 broader [2] 27/13 167/23 broadly [5] 39/14
----------	--	--	---	--

B	63/21 64/2 64/5 65/23 70/23 79/23 83/23 86/10 89/18 91/9 91/15 94/15 96/6 98/20 102/21 103/9 107/12 107/17 107/24 108/2 110/12 111/10 114/19 118/4 118/10 122/20 122/24 126/2 129/24 132/5 132/18 135/22 136/22 137/13 138/8 139/17 142/6 146/2 148/12 153/12 154/10 154/19 156/1 156/2 156/25 162/3 162/19 163/21 167/24 169/15 170/9 174/4 178/15 182/5 184/15 184/20 184/22 185/2 186/25 189/12 189/23 191/21 192/17 195/1 196/20 198/24 199/14 200/13 201/19 202/1 202/1 202/14 202/19 202/24 203/9 203/20 204/6 206/5 206/16 206/25 208/2	81/20 82/6 92/5 92/17 99/4 99/7 99/8 99/18 100/2 100/6 100/9 100/10 112/22 113/1 113/3 113/4 113/8 113/11 121/22 121/22 122/11 123/23 124/14 124/15 125/2 125/3 125/5 125/6 125/15 125/18 125/20 126/8 128/9 133/8 133/11 133/20 133/22 134/1 134/1 134/3 134/5 134/8 134/11 134/21 134/23 135/5 135/7 135/21 135/24 136/7 136/23 137/8 140/15 148/21 148/24 156/15 158/21 164/5 164/9 164/10 164/12 164/19 165/2 169/23 169/25 171/1 172/1 172/16 172/19 173/2 179/8 180/3 180/4 181/19 181/20 183/5 184/23 189/8 189/11 189/13 191/12 192/16 205/22 206/13	catch [1] 188/11 catchment [1] 60/2 categories [2] 83/15 193/13 categorisation [1] 163/4 category [2] 163/1 163/3 caught [1] 47/16 causal [1] 154/20 cause [3] 72/25 75/13 196/5 caused [3] 6/8 28/21 172/7 causes [6] 86/23 144/4 145/18 145/19 152/18 195/3 cautioning [1] 20/14 cell [1] 22/16 cent [1] 75/18 centigrade [1] 38/18 central [14] 43/12 51/11 72/19 96/12 106/8 112/4 113/25 127/2 147/13 164/9 174/16 176/12 176/17 192/17 centralisation [4] 147/5 147/7 147/22 174/23 centralised [2] 173/1 175/1 centrally [1] 147/17 centre [21] 48/16 48/18 49/24 53/11 58/11 61/20 62/21 71/13 81/18 84/20 84/21 84/23 93/6 121/25 127/3 127/4 127/11 127/19 132/15 144/20 205/22 centres [35] 12/23 17/4 17/5 17/25 18/1 18/4 39/6 46/5 48/10 52/10 54/19 59/5 59/7 61/16 62/1 62/5 81/16 82/12 84/13 89/8 93/11 103/9 103/10 121/21 122/10 122/13 124/17 126/7 126/7 126/13 167/13 180/4 180/5 192/17 205/12 centric [1] 78/17 cerebral [1] 103/18 certain [20] 19/12 28/22 50/13 50/17 68/17 114/21 129/15 131/7 138/7 141/3 147/15 152/24 158/1 169/1 174/17 174/17 195/12 200/2 200/11 202/3 certainly [18] 47/17 50/10 85/20 87/10	110/15 115/11 119/22 121/7 127/8 132/2 136/14 157/17 160/21 162/15 175/6 203/13 203/14 204/9 cetera [10] 83/3 101/7 112/2 112/2 118/21 129/7 129/8 139/5 139/5 194/16 Chada [11] 107/12 107/13 107/15 107/18 107/19 133/2 137/18 140/2 141/8 141/12 210/13 chain [4] 6/24 34/14 80/5 159/22 chains [2] 23/20 146/23 chair [3] 65/23 69/14 73/22 chaired [3] 68/4 74/16 116/6 chairmanship [1] 116/13 challenge [4] 59/9 79/14 92/9 99/11 challenged [1] 43/18 challenges [7] 10/23 44/14 44/15 79/18 131/5 134/7 162/2 challenging [2] 36/5 123/11 Champion [1] 201/1 champions [1] 53/7 chance [4] 5/15 77/6 101/10 167/1 change [6] 17/1 20/11 70/23 114/16 138/8 177/23 changed [5] 17/20 43/18 54/15 136/9 175/25 changes [5] 16/19 16/24 138/13 177/13 177/21 changing [3] 21/10 99/25 180/2 Chantler [17] 15/13 142/15 142/18 142/23 142/24 143/11 144/8 146/4 168/16 170/14 174/24 178/1 185/14 190/24 195/4 197/3 210/19 chaotic [1] 93/19 characteristics [5] 83/18 129/15 169/7 170/6 208/15 charge [2] 67/25 116/8 charged [3] 91/13 91/21 91/25 charging [2] 89/20 90/24
C	Cabinet [8] 3/10 3/12 40/25 51/3 51/3 57/3 98/19 148/17 cadre [1] 171/10 calculation [1] 75/14 call [13] 8/13 14/18 20/13 21/9 21/14 21/14 49/18 55/12 57/11 83/3 148/9 161/17 166/13 call-up [1] 20/13 call/recall [1] 83/3 called [10] 11/22 18/5 32/5 43/22 55/21 126/1 127/12 148/11 165/25 193/20 calling [5] 13/8 29/25 32/13 60/7 101/8 calls [1] 49/17 came [23] 11/3 18/19 23/19 41/4 41/8 44/10 46/3 60/14 66/16 75/19 78/16 82/10 89/20 92/20 94/9 97/18 124/17 125/6 170/13 173/16 175/20 178/6 194/13 campaign [5] 18/5 109/1 132/7 133/5 139/25 campaigns [4] 51/25 66/24 144/1 144/2 can [99] 5/14 7/9 8/24 8/25 11/13 34/23 37/24 38/25 39/12 40/24 45/11 45/12 45/13 51/16 52/2 58/17 59/4 63/16	263/21 264/2 264/5 265/23 270/23 279/23 283/23 286/10 289/18 291/9 291/15 294/15 296/6 298/20 302/21 303/9 307/12 307/17 307/24 308/2 310/12 311/10 314/19 318/4 318/10 322/20 322/24 326/2 329/24 332/5 332/18 335/22 336/22 337/13 338/8 339/17 342/6 346/2 348/12 353/12 354/10 354/19 356/1 356/2 356/25 362/3 362/19 363/21 367/24 369/15 370/9 374/4 378/15 382/5 384/15 384/20 384/22 385/2 386/25 389/12 389/23 391/21 392/17 395/1 396/20 398/24 399/14 400/13 401/19 402/1 402/1 402/14 402/19 402/24 403/9 403/20 404/6 406/5 406/16 406/25 408/2 can't [13] 16/15 16/23 23/11 32/4 38/22 56/22 61/20 119/23 120/6 132/15 134/17 162/8 204/23 candid [3] 16/23 54/13 77/7 candidate [1] 66/1 candour [1] 27/24 cannot [3] 14/19 24/10 200/8 capabilities [3] 126/24 128/25 129/9 capability [1] 129/12 capable [1] 128/17 capacity [3] 25/2 69/7 168/18 capture [2] 83/3 127/24 captured [3] 98/4 98/6 192/23 car [2] 49/22 94/2 Card [5] 101/23 102/12 139/10 140/6 140/9 Cardiff [1] 149/6 care [122] 3/13 5/11 5/12 5/13 7/14 10/21 10/25 11/16 12/21 13/4 13/10 13/12 14/4 15/16 15/17 15/20 16/5 16/6 16/8 16/9 25/5 25/17 25/18 25/22 30/1 31/16 39/3 44/12 44/12 61/14 61/19 64/14 66/8 66/8 70/2 70/2 75/18 81/16	career [2] 115/12 115/16 carefully [5] 23/23 30/3 123/6 138/12 208/25 carer [6] 40/3 41/17 41/21 42/20 96/3 161/8 Carer's [2] 161/12 161/13 carers [27] 26/25 39/25 40/24 41/5 41/13 41/20 42/1 42/9 42/25 43/4 95/14 95/18 96/1 96/7 96/11 96/24 100/12 161/3 161/9 161/11 161/17 161/19 161/20 165/2 182/3 182/4 193/7 careworkers [4] 164/1 164/2 164/5 193/8 Caribbean [8] 187/10 187/16 188/4 188/9 189/17 190/12 196/16 198/13 carried [5] 46/11 125/24 131/6 138/5 153/6 carry [2] 50/2 127/18 carrying [1] 121/2 case [6] 10/14 103/11 144/8 155/3 189/14 192/8 cases [5] 4/25 5/16 103/1 103/4 103/13	catch [1] 188/11 catchment [1] 60/2 categories [2] 83/15 193/13 categorisation [1] 163/4 category [2] 163/1 163/3 caught [1] 47/16 causal [1] 154/20 cause [3] 72/25 75/13 196/5 caused [3] 6/8 28/21 172/7 causes [6] 86/23 144/4 145/18 145/19 152/18 195/3 cautioning [1] 20/14 cell [1] 22/16 cent [1] 75/18 centigrade [1] 38/18 central [14] 43/12 51/11 72/19 96/12 106/8 112/4 113/25 127/2 147/13 164/9 174/16 176/12 176/17 192/17 centralisation [4] 147/5 147/7 147/22 174/23 centralised [2] 173/1 175/1 centrally [1] 147/17 centre [21] 48/16 48/18 49/24 53/11 58/11 61/20 62/21 71/13 81/18 84/20 84/21 84/23 93/6 121/25 127/3 127/4 127/11 127/19 132/15 144/20 205/22 centres [35] 12/23 17/4 17/5 17/25 18/1 18/4 39/6 46/5 48/10 52/10 54/19 59/5 59/7 61/16 62/1 62/5 81/16 82/12 84/13 89/8 93/11 103/9 103/10 121/21 122/10 122/13 124/17 126/7 126/7 126/13 167/13 180/4 180/5 192/17 205/12 centric [1] 78/17 cerebral [1] 103/18 certain [20] 19/12 28/22 50/13 50/17 68/17 114/21 129/15 131/7 138/7 141/3 147/15 152/24 158/1 169/1 174/17 174/17 195/12 200/2 200/11 202/3 certainly [18] 47/17 50/10 85/20 87/10

C				
<p>charitable [1] 53/7 charity [1] 97/8 chart [8] 148/7 185/17 185/23 186/10 186/16 186/21 186/23 187/25 charts [2] 185/10 185/15 check [3] 18/7 28/12 131/10 checks [2] 97/21 201/6 chief [22] 2/14 2/14 6/17 6/18 15/23 65/11 66/25 67/14 68/3 71/11 72/3 99/25 100/1 108/10 108/14 109/10 116/6 116/14 120/13 120/14 135/18 135/19 child [8] 46/18 47/3 48/2 83/2 161/12 166/25 167/4 167/25 child-friendly [1] 47/3 childcare [1] 99/20 childhood [7] 5/4 112/1 128/4 128/5 144/3 165/18 199/21 children [14] 46/10 47/6 47/12 48/5 76/7 86/20 165/8 165/14 165/20 166/7 166/11 167/2 168/8 203/15 choice [1] 167/7 choose [1] 168/5 Christian [1] 137/19 Christian Weaver [1] 137/19 Christmas [1] 118/13 chronologically [1] 146/19 churches [1] 54/20 circumstances [1] 123/8 civil [4] 1/17 32/2 65/10 71/10 civilian [1] 127/14 Claire [2] 67/1 71/10 Claire Rowlands [1] 71/10 clarification [2] 69/15 69/22 clarify [2] 101/18 152/15 classification [1] 97/17 clear [20] 26/21 50/1 52/9 79/17 90/21 133/24 140/5 146/17 158/23 164/21 164/24 177/11 178/19 182/4</p>	<p>191/7 192/7 192/22 194/23 199/25 200/10 clearly [6] 33/24 60/10 120/15 138/4 189/25 190/6 client [1] 89/19 clients [1] 69/5 clinic [2] 21/23 165/22 clinic-based [1] 165/22 clinical [19] 2/9 2/11 2/12 9/15 27/10 44/25 48/5 68/24 69/9 71/9 74/8 89/24 93/7 95/16 95/25 108/16 157/9 157/14 170/22 clinically [13] 44/24 59/13 62/11 76/12 93/12 123/18 158/2 159/5 204/25 205/7 205/10 205/18 206/15 clinician [1] 19/16 clinicians [8] 2/13 6/17 12/21 87/2 102/16 102/24 103/20 103/25 clinics [10] 39/4 43/16 45/13 47/4 52/4 93/23 122/13 171/20 201/5 201/6 close [6] 2/8 2/4/4 75/19 96/5 126/22 126/23 closely [10] 3/7 27/21 79/11 92/16 93/3 93/20 96/18 110/12 151/6 151/11 closer [5] 93/18 152/23 174/3 182/14 197/24 closing [1] 84/20 cluster [1] 93/1 clusters [3] 83/14 88/21 92/22 CMO [5] 6/18 65/17 65/18 66/18 67/8 CMOs [2] 148/18 165/12 CNO [1] 6/18 co [3] 71/14 109/25 144/19 co-direct [1] 144/19 co-ordination [2] 71/14 109/25 coalface [1] 23/25 Coast [1] 47/5 code [2] 20/24 21/17 codes [2] 22/9 193/14 coercion [1] 99/1 coherent [1] 147/20 cohort [30] 21/12 29/19 39/11 39/19</p>	<p>39/20 39/23 40/23 41/18 55/18 62/8 83/16 94/14 94/14 94/20 94/21 94/24 97/15 97/16 158/4 163/6 163/7 163/14 164/3 164/6 164/15 167/22 205/20 207/21 207/22 208/7 cohort 1 [1] 164/6 cohort 4 [1] 163/7 cohort 6 [7] 39/20 39/23 40/23 55/18 97/16 158/4 163/6 cohorts [24] 39/8 44/10 44/22 46/3 55/14 56/25 60/15 62/7 94/24 95/10 126/3 126/22 157/10 158/3 158/4 159/3 160/3 165/5 168/1 170/7 186/14 187/7 194/15 205/6 cohorts 6 [1] 158/4 coincide [1] 4/25 collaboration [3] 78/21 152/3 152/23 collaborative [2] 144/20 151/9 colleague [1] 71/10 colleagues [14] 20/13 21/5 35/5 35/14 40/9 62/25 64/11 64/19 64/20 99/13 116/9 132/21 141/17 209/2 collected [1] 194/17 collecting [1] 192/12 collection [1] 173/18 collectively [2] 4/22 71/16 College [1] 145/4 collegiate [1] 119/14 colonialism [1] 105/14 coma [1] 101/3 combat [1] 127/15 combination [4] 165/22 180/5 197/12 197/16 combined [4] 17/19 31/25 75/10 180/12 combining [2] 5/18 5/24 come [34] 3/17 5/21 9/25 15/5 27/1 41/3 41/4 45/14 46/7 57/5 57/11 59/3 62/17 66/3 69/9 74/13 79/9 80/23 90/15 90/17 96/7 100/12 108/22 112/17 122/20 141/13 157/10 164/20 176/23 178/22 184/9 197/1 197/1</p>	<p>197/25 comes [10] 92/5 129/13 132/8 141/7 158/8 177/13 181/10 181/13 183/9 204/15 coming [8] 29/4 62/21 80/12 85/3 124/24 176/1 177/17 201/22 commence [2] 1/8 142/20 commencement [1] 19/21 commencing [1] 94/13 comment [8] 16/15 28/17 30/24 31/20 31/24 102/4 134/17 208/3 commentary [1] 30/12 comments [2] 28/20 30/17 commission [2] 71/1 166/16 commissioned [3] 15/12 128/14 143/3 commissioning [2] 169/22 173/21 committee [10] 72/20 87/24 87/25 88/9 88/20 97/10 183/17 183/19 183/25 201/14 committees [5] 176/3 182/21 183/1 183/23 184/2 common [1] 162/16 comms [3] 22/3 34/7 61/3 communicate [1] 121/6 communicated [2] 110/23 140/20 communicating [2] 120/2 120/8 communication [14] 34/1 34/11 51/19 51/24 53/9 67/8 76/20 115/6 121/1 121/8 121/8 147/10 175/3 195/8 communications [11] 6/25 30/5 34/2 34/3 34/11 51/23 106/13 110/2 116/10 117/4 120/12 communities [44] 21/21 43/6 43/9 50/14 53/9 53/24 54/22 81/19 86/3 86/4 88/23 89/9 92/9 92/13 92/16 93/14 105/20 105/23 106/2 106/3 106/4</p>	<p>106/15 124/6 131/24 143/19 153/18 155/25 176/17 177/16 179/25 180/8 190/16 193/16 195/12 195/17 195/20 196/20 198/20 198/21 199/2 200/5 200/11 200/13 202/3 community [53] 10/8 21/23 39/4 44/1 47/1 47/20 47/21 47/23 49/8 51/17 53/6 54/5 54/18 61/3 66/5 82/1 87/17 88/21 89/8 92/18 106/7 113/7 113/10 121/25 122/11 125/11 131/3 152/23 154/14 165/22 173/9 173/12 173/14 173/16 173/25 174/6 174/12 175/10 176/15 176/24 177/6 178/5 178/8 178/22 179/4 183/4 189/16 192/16 193/22 199/13 199/16 201/1 202/6 community-based [1] 47/20 community-focused [1] 113/10 Company [1] 57/24 compared [6] 86/3 86/6 86/8 86/8 187/5 187/11 comparing [1] 86/5 comparison [5] 15/14 18/10 147/23 152/13 198/12 compensation [3] 100/24 101/5 101/18 complacent [1] 200/8 complained [1] 31/18 complementary [1] 111/6 complete [2] 175/8 180/15 completed [1] 121/23 completely [7] 6/3 26/16 59/9 78/3 93/2 101/6 195/14 completes [2] 57/19 141/11 completing [1] 34/18 completion [1] 34/16 complex [9] 20/19 21/1 143/2 146/11 146/16 148/6 148/12 197/3 197/9 complexities [3] 58/21 178/24 179/10 complexity [4] 11/4 20/21 26/24 194/10</p>

C				
<p>complicated [5] 39/20 70/8 139/6 139/13 190/22</p> <p>complimentary [1] 71/2</p> <p>comprehensive [1] 208/7</p> <p>compressed [2] 18/13 18/17</p> <p>comprise [1] 137/20</p> <p>conception [1] 71/21</p> <p>concepts [1] 139/13</p> <p>concern [3] 94/8 174/25 188/23</p> <p>concerned [18] 1/21 2/2 3/1 4/19 4/22 7/6 9/7 24/19 31/11 79/24 91/20 133/7 146/22 148/14 158/16 174/5 188/9 194/1</p> <p>concerning [9] 30/13 34/2 36/15 50/13 146/24 153/14 195/7 195/10 197/6</p> <p>concerns [12] 46/23 74/24 87/3 90/25 96/1 99/17 104/9 162/12 166/4 175/5 192/3 205/11</p> <p>conclude [1] 182/13</p> <p>concludes [1] 57/18</p> <p>conclusions [3] 184/11 185/5 202/20</p> <p>condense [1] 19/6</p> <p>condition [2] 98/12 133/19</p> <p>conditions [2] 138/7 189/1</p> <p>conduct [1] 153/24</p> <p>conducted [3] 24/22 85/19 180/24</p> <p>conducting [1] 153/19</p> <p>Conference [1] 48/16</p> <p>confidence [21] 14/23 28/25 29/1 29/4 29/13 33/22 33/25 35/21 50/19 78/12 90/16 91/1 131/25 138/10 138/23 139/1 139/14 139/18 140/4 198/16 198/16</p> <p>confident [3] 11/6 91/6 139/20</p> <p>confirm [2] 64/2 107/24</p> <p>confirmation [1] 105/7</p> <p>confused [1] 26/6</p> <p>confusion [3] 59/25 60/4 138/14</p> <p>congratulate [1]</p>	<p>100/4</p> <p>connected [2] 137/3 197/6</p> <p>conscious [1] 133/15</p> <p>consent [3] 46/22 166/18 166/19</p> <p>consequence [2] 103/2 103/7</p> <p>consequences [1] 38/17</p> <p>Conservative [1] 37/3</p> <p>consider [6] 40/3 51/22 51/23 72/7 73/24 77/22</p> <p>considerable [4] 25/12 143/23 173/10 187/2</p> <p>consideration [4] 60/2 60/21 61/24 62/3</p> <p>considered [2] 73/23 208/25</p> <p>considering [3] 57/1 105/16 138/13</p> <p>consist [2] 5/22 6/16</p> <p>consisted [1] 11/14</p> <p>consistency [5] 155/6 162/5 163/13 167/23 170/13</p> <p>consistent [4] 147/19 151/5 160/18 172/12</p> <p>consistently [1] 187/17</p> <p>constantly [2] 17/1 21/9</p> <p>constituted [2] 81/2 84/12</p> <p>constitution [1] 7/21</p> <p>constrained [4] 11/8 58/1 124/22 124/25</p> <p>constraining [1] 10/22</p> <p>constraints [1] 11/2</p> <p>consultant [1] 64/24</p> <p>consultation [2] 77/23 151/23</p> <p>consulted [3] 69/2 95/24 161/15</p> <p>contact [3] 2/10 76/23 134/22</p> <p>contained [3] 145/8 146/9 159/11</p> <p>contains [2] 64/1 107/23</p> <p>content [2] 13/21 13/24</p> <p>contents [2] 64/4 108/1</p> <p>context [14] 14/12 33/1 47/19 99/2 124/2 137/21 154/7 156/7 159/22 160/8 161/2 174/22 195/24 207/24</p>	<p>continually [1] 20/11</p> <p>continue [3] 37/8 67/4 100/3</p> <p>continuing [1] 201/21</p> <p>continuous [2] 80/11 158/24</p> <p>continuously [3] 99/23 177/4 200/8</p> <p>contract [1] 8/16</p> <p>contracted [1] 123/9</p> <p>contractors [2] 64/14 92/18</p> <p>contracts [6] 169/9 169/10 169/12 169/15 169/18 170/2</p> <p>contradiction [2] 133/24 136/20</p> <p>contrast [2] 13/15 13/16</p> <p>contribute [6] 109/14 110/1 117/18 118/6 118/18 119/17</p> <p>contributed [1] 98/19</p> <p>contributing [1] 154/21</p> <p>contribution [3] 45/24 77/13 179/4</p> <p>contributions [1] 119/10</p> <p>control [2] 112/4 175/1</p> <p>controls [1] 42/16</p> <p>convenience [2] 81/19 205/2</p> <p>convenient [1] 160/20</p> <p>conversation [1] 32/24</p> <p>conversations [5] 47/4 48/3 77/5 104/7 196/2</p> <p>convert [1] 83/2</p> <p>COO [1] 71/12</p> <p>cooperation [4] 24/4 114/14 115/8 115/10</p> <p>coordinate [1] 67/11</p> <p>copied [1] 36/20</p> <p>core [9] 61/10 67/10 68/6 105/16 105/22 110/9 171/22 177/5 203/18</p> <p>correct [45] 2/4 3/2 3/6 4/1 4/17 10/9 12/18 14/1 14/10 15/19 31/1 31/12 31/13 31/22 34/12 35/20 38/15 39/13 39/15 40/4 42/3 55/2 65/1 65/12 72/18 94/18 108/6 108/12 115/25 116/24 127/25 128/1 143/10 143/12 143/21 144/12 144/17</p>	<p>144/23 145/6 147/15 163/8 184/1 186/14 186/15 197/23</p> <p>corrected [1] 31/2</p> <p>correcting [1] 33/7</p> <p>correction [2] 28/19 187/24</p> <p>correctly [3] 30/18 84/12 109/5</p> <p>could [98] 1/8 11/6 21/2 21/24 22/2 22/2 22/3 23/22 33/24 35/23 37/10 38/21 40/11 45/17 49/12 49/18 49/18 51/12 53/1 54/8 54/9 58/9 60/16 62/13 69/2 72/11 74/25 77/17 79/5 79/9 80/7 80/9 80/15 80/19 80/23 81/1 81/2 82/2 84/23 85/10 85/18 93/13 94/4 94/23 94/24 96/13 98/6 99/11 103/18 104/5 112/18 112/18 114/7 117/19 117/21 118/1 118/3 119/2 119/10 122/24 123/7 125/7 127/21 133/10 133/25 134/2 137/2 137/7 138/21 140/4 142/15 142/20 150/3 151/25 153/3 153/6 155/17 161/5 162/5 163/18 168/12 168/13 171/16 171/17 172/11 173/13 174/2 175/15 176/25 178/17 178/21 186/4 194/18 201/16 203/25 205/16 206/6 206/9</p> <p>couldn't [10] 14/24 16/5 18/23 21/2 49/23 91/17 118/7 131/17 173/8 173/23</p> <p>Council [1] 106/8</p> <p>COUNSEL [8] 1/7 63/18 107/14 142/19 210/4 210/10 210/14 210/20</p> <p>countries [4] 75/7 153/10 181/23 199/8</p> <p>country [9] 75/4 76/8 78/14 106/21 115/17 148/23 158/8 185/19 194/11</p> <p>county [1] 81/18</p> <p>couple [4] 31/7 42/16 89/10 131/19</p> <p>course [45] 5/6 10/17 16/20 21/18 22/6 26/6 33/14 38/9 42/22 44/16 45/10 65/15 72/21 78/6 88/25</p>	<p>90/22 94/5 98/14 100/16 101/25 112/17 113/14 133/14 136/10 141/17 146/23 148/23 151/10 157/2 157/8 160/10 167/24 169/11 172/2 179/19 182/8 188/17 191/16 193/3 193/18 194/1 203/23 203/23 207/22 209/1</p> <p>courses [1] 71/6</p> <p>cousin [1] 60/23</p> <p>CoV [1] 16/18</p> <p>cover [3] 65/10 147/1 170/3</p> <p>coverage [14] 11/6 99/8 99/9 143/6 143/18 145/16 185/11 187/5 191/24 192/20 194/15 199/10 202/11 207/9</p> <p>covered [5] 82/13 123/3 185/7 188/8 188/14</p> <p>covers [1] 1/23</p> <p>Covid [67] 3/18 4/20 4/25 5/7 5/9 5/19 5/25 7/11 8/5 9/2 13/4 17/19 18/15 22/24 37/12 38/2 46/20 51/4 53/3 57/24 58/6 59/21 59/25 61/14 65/15 65/18 65/19 65/21 66/13 68/4 70/18 70/20 90/22 103/1 105/2 109/11 112/10 115/25 129/5 129/19 133/5 136/1 137/4 137/20 140/12 151/16 152/10 154/7 155/3 156/8 160/8 170/13 178/2 179/20 180/6 182/6 182/8 184/10 185/18 187/6 188/2 191/24 192/10 198/13 198/14 202/16 207/19</p> <p>Covid-19 [29] 7/11 13/4 18/15 38/2 53/3 65/18 65/19 66/13 68/4 70/18 70/20 90/22 105/2 137/4 140/12 151/16 152/10 154/7 155/3 156/8 160/8 178/2 182/6 182/8 185/18 187/6 191/24 192/10 202/16</p> <p>create [5] 29/3 117/14 119/20 177/23 196/20</p> <p>created [3] 6/13 182/24 184/3</p> <p>creating [2] 9/11 147/18</p> <p>creation [2] 7/23</p>

C	22/5 58/8 58/13 58/25 59/2 76/19 76/19 77/4 77/4 84/16 84/17 85/2 117/9 117/9 127/21 128/22 166/15 166/20 209/9	definition [7] 41/21 45/5 50/4 55/11 95/17 95/18 96/1	146/21	Derek [6] 1/5 1/6 1/10 32/23 36/3 210/3	
creation... [1] 176/14		definitional [3] 40/1 41/16 163/10	demographic [4] 23/3 114/19 128/18 129/15	descending [1] 160/9	
credibility [2] 53/22 53/24		defrosted [1] 58/16	demographics [1] 194/16	describe [5] 67/10 67/13 121/13 126/1 128/3	
credit [2] 22/13 56/22	Dayle [4] 104/18	degree [12] 17/10 27/23 49/11 50/13 147/7 147/22 152/2 175/1 177/19 183/3 184/25 192/1	demonstrate [1] 202/2	described [8] 6/6 25/24 59/24 62/9 67/12 72/25 105/21 143/18	
cremations [1] 1/25	days [3] 19/7 117/15 174/17	degrees [1] 38/18	demonstrated [3] 47/10 115/16 118/23	deserved [1] 136/13	
crisis [3] 87/11 87/14 102/8	deal [23] 21/1 22/7 23/22 48/8 67/7 80/15 111/1 117/1 130/11 130/17 130/25 145/23 161/5 165/10 165/17 172/16 174/10 175/8 179/15 181/17 194/3 201/15 204/7	delay [3] 107/15 165/15 172/7	demonstrates [2] 122/7 122/14	design [6] 70/15 154/18 176/16 177/3 189/19 189/21	
criteria [1] 161/11	dealing [7] 28/12 70/4 129/20 130/6 168/17 174/23 183/20	delays [1] 24/11	demonstrating [1] 185/11	designed [4] 8/11 8/17 85/7 175/2	
critical [1] 196/13	dealt [2] 35/16 204/19	delegated [2] 70/6 71/20	Denbighshire [1] 92/25	designing [1] 175/9	
criticisms [1] 30/8	death [1] 190/6	delighted [1] 92/21	dented [1] 33/25	desire [1] 195/12	
crucial [6] 69/18 155/12 167/7 177/21 192/14 192/19	debate [5] 33/10 33/11 41/16 41/16 165/9	deliver [12] 7/14 7/15 17/22 64/18 93/18 106/21 166/22 170/23 173/22 178/9 179/8 201/19	dentists [2] 12/21 49/2	despite [1] 26/15	
crucially [1] 205/20	debated [1] 28/5	delivered [23] 4/13 5/7 6/7 11/2 11/19 15/15 26/1 26/5 30/20 38/18 46/18 48/19 53/17 59/21 60/10 93/16 122/24 146/25 149/10 149/11 167/21 168/13 192/15	department [13] 25/16 25/18 25/22 32/7 108/8 108/13 110/10 112/4 112/11 128/9 130/15 133/15 178/1	detail [12] 7/13 25/25 67/19 84/2 88/24 89/11 114/19 118/20 128/4 134/18 169/11 170/3	
cultural [2] 87/7 106/2	debates [1] 201/3	deliveries [1] 80/2	departmental [1] 26/9	detailed [3] 38/9 104/1 143/2	
cumbersome [1] 116/4	December [11] 13/18 13/20 17/11 32/20 33/21 38/11 38/14 76/14 128/23 159/25 172/5	delivering [8] 17/8 30/14 106/24 150/1 165/19 166/14 177/15 178/24	dependent [1] 114/23	detected [2] 138/16 138/20	
cutting [1] 81/4	decentralisation [3] 148/2 182/17 182/18	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	deployment [1] 114/23	details [1] 187/13	
cycle [1] 146/11	decide [2] 52/11 72/15	delivered [29] 13/4 15/10 17/17 22/19 23/12 24/6 24/9 34/25 35/4 37/16 38/2 38/22 40/6 43/15 50/8 62/7 70/11 78/9 94/9 98/12 102/5 112/11 112/23 115/20 116/8 133/20 148/15 159/24 168/17	developing [3] 109/1 199/20 205/25	detecting [1] 153/12	
D	decided [5] 25/22 27/7 66/6 97/24 112/3	deliveries [1] 80/2	depiction [1] 122/5	determining [1] 51/5	
Dabush [13] 15/13 142/14 142/17 142/22 143/13 155/1 156/25 161/4 185/4 190/1 191/22 203/3 210/18	decide [2] 52/11 72/15	delivering [8] 17/8 30/14 106/24 150/1 165/19 166/14 177/15 178/24	deployment [11] 44/10 51/9 80/24 110/21 112/20 120/4 122/16 123/7 125/13 125/13 145/19	determine [1] 153/12	
Dabush's [1] 197/1	decision [8] 4/21 16/7 24/16 69/11 73/13 98/16 105/4 158/25	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	deploy [11] 29/7 46/4 49/19 80/10 80/13 110/6 113/7 122/8 124/5 125/7 127/15	develop [6] 20/1 40/21 47/3 52/15 68/6 83/17	
daily [3] 58/12 83/20 133/11	decide [2] 52/11 72/15	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	developed [8] 40/10 82/23 129/8 139/4 139/21 166/23 182/7 193/24	development [4] 65/25 68/9 111/20 128/25	
damage [4] 101/1 101/21 103/11 142/7	decided [5] 25/22 27/7 66/6 97/24 112/3	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	developing [9] 8/12 9/7 9/11 19/4 19/5 20/14 43/14 175/9 182/20	deviating [1] 59/9	
damaged [1] 87/15	declared [2] 42/19 90/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	devoted [42] 6/3 11/24 25/14 26/5 27/16 27/19 28/16 31/20 33/13 33/15 36/12 36/23 37/6 43/11 73/21 74/1 74/6 100/21 109/23 113/25 114/17 115/13 117/18 118/15 119/11 119/15 122/16 147/18 148/13 151/4 151/11 151/18 151/24 153/2 155/7 156/15 160/17 172/21 178/13 179/1 192/10 194/24	devolution [1] 25/7	
Dame [1] 40/12	decor [1] 48/3	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	depression [1] 35/24	devolved [42] 6/3 11/24 25/14 26/5 27/16 27/19 28/16 31/20 33/13 33/15 36/12 36/23 37/6 43/11 73/21 74/1 74/6 100/21 109/23 113/25 114/17 115/13 117/18 118/15 119/11 119/15 122/16 147/18 148/13 151/4 151/11 151/18 151/24 153/2 155/7 156/15 160/17 172/21 178/13 179/1 192/10 194/24	DHC [1] 117/24
danger [1] 95/8	dedicate [1] 85/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	deprivation [7] 88/17 130/1 130/21 132/4 174/2 191/1 197/14	DHSC [1] 176/12	
dare [1] 143/2	deep [2] 53/25 197/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	deprived [8] 86/2 86/4 130/12 158/18 191/3 191/5 191/10 191/10		
data [54] 19/9 19/24 20/4 20/25 21/17 22/9 22/17 36/12 36/25 37/7 42/1 42/10 52/5 52/18 56/7 70/1 83/3 89/24 89/24 90/1 127/24 132/3 138/9 140/20 141/6 154/24 154/24 187/24 190/9 190/19 190/21 191/21 191/23 191/25 192/4 192/6 192/18 192/25 193/1 193/7 193/24 194/4 194/6 194/8 194/8 194/14 194/17 194/21 204/4 204/4 207/15 207/17 208/4 208/14	declared [2] 42/19 90/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17	deputy [5] 65/4 66/25 108/10 108/14 109/10		
dataset [1] 20/1	decree [1] 157/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17			
date [3] 29/18 32/8 79/13	dedicate [1] 85/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17			
dated [5] 1/13 13/17 51/13 63/25 107/22	deep-seated [1] 197/6	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 112/17 117/15 118/20 121/18 121/20 124/10 143/6 144/22 146/22 147/3 147/8 147/14 149/5 150/13 150/23 152/6 152/22 153/10 154/15 156/19 156/20 157/7 165/21 165/23 165/25 166/3 168/23 170/14 170/15 172/4 176/16 177/15 178/3 178/10 179/14 179/19 179/24 181/2 181/17 181/18 189/21 197/5 201/8 201/20 203/8 205/17			
dates [1] 118/11	deeper [1] 32/23	delivery [79] 6/3 6/11 6/14 7/10 11/17 17/3 18/16 24/11 27/14 36/4 36/16 38/3 43/8 44/7 45/1 50/24 51/15 52/3 66/4 68/2 68/6 68/22 70/21 71/6 77/9 78/16 79/22 80/18 81/5 81/16 86/20 93/1 104/3 1			

<p>D</p> <p>diabetes [1] 171/20</p> <p>did [149] 1/18 1/20 2/18 2/21 2/22 3/9 3/17 4/8 4/14 5/9 5/12 6/9 6/16 7/2 8/9 10/10 10/18 10/19 12/13 12/19 13/14 15/22 16/5 19/25 23/2 26/11 28/3 31/4 32/6 32/6 34/16 34/21 37/7 37/9 37/11 38/2 39/10 39/14 39/24 41/3 42/16 43/2 43/7 43/21 44/8 45/2 45/14 45/23 45/24 46/14 46/14 46/15 46/16 48/7 48/21 48/22 48/24 48/24 49/16 49/20 50/17 52/10 53/20 54/8 54/9 55/3 55/8 55/16 56/15 57/8 58/7 58/11 58/19 58/24 63/3 66/12 67/4 67/19 67/23 68/12 68/14 68/23 69/4 69/13 70/8 70/14 72/24 72/25 73/21 74/12 80/22 84/19 85/14 88/9 91/18 95/20 95/23 96/22 97/5 97/8 98/21 99/12 99/14 102/1 102/18 104/14 108/16 108/20 108/22 114/8 116/25 119/20 122/22 123/21 124/8 124/9 127/13 128/12 128/14 128/24 131/11 132/16 141/17 148/3 150/24 151/8 154/25 155/16 157/15 157/15 160/5 163/9 164/9 167/5 167/9 169/3 169/24 173/13 174/13 178/22 179/23 181/22 198/1 198/12 198/25 199/8 200/1 200/4 209/1</p> <p>didn't [43] 10/25 11/5 11/9 12/19 14/22 15/6 21/13 21/14 23/16 26/16 27/13 30/2 32/5 34/19 34/20 35/7 38/9 38/12 38/16 41/4 45/1 47/7 49/12 55/6 58/2 61/5 61/6 61/8 69/24 72/18 73/18 73/19 80/7 81/11 90/25 100/12 119/12 127/1 149/23 155/19 188/11 192/18 192/21</p> <p>differ [1] 46/16</p> <p>differed [1] 56/2</p> <p>difference [10] 24/2</p>	<p>86/7 92/4 119/13 136/16 155/5 189/22 191/2 191/6 191/9</p> <p>differences [15] 29/23 30/2 60/3 60/5 60/19 60/20 60/22 61/5 114/20 122/18 145/14 145/21 151/21 165/19 191/9</p> <p>different [56] 5/7 20/12 20/12 20/12 21/25 26/18 27/6 29/20 29/24 32/13 33/19 40/18 49/10 54/16 54/19 56/5 59/21 59/22 60/1 73/1 73/2 75/6 78/9 87/9 89/3 98/11 109/12 113/12 114/3 114/20 117/12 119/11 129/17 131/2 131/2 132/3 136/19 139/7 148/5 148/17 152/21 156/14 156/25 157/4 157/10 159/6 164/14 165/1 175/13 178/16 178/20 181/17 192/13 195/9 196/19 201/10</p> <p>differently [6] 46/14 60/25 69/13 80/21 87/9 181/22</p> <p>difficult [16] 21/5 26/14 29/8 29/8 30/21 45/4 45/11 63/1 78/4 87/14 93/11 98/1 99/13 133/18 154/4 170/3</p> <p>difficulties [7] 14/2 67/13 72/25 118/3 152/13 163/11 168/21</p> <p>difficulty [2] 42/4 90/24</p> <p>dig [1] 37/4</p> <p>digital [7] 9/6 9/12 9/15 19/14 56/13 56/15 195/9</p> <p>diluted [1] 58/17</p> <p>direct [3] 80/2 120/17 144/19</p> <p>directed [3] 44/12 147/17 148/1</p> <p>direction [1] 52/8</p> <p>directions [1] 40/16</p> <p>directive [1] 178/19</p> <p>directives [1] 50/22</p> <p>directly [6] 19/15 52/20 90/18 116/13 116/16 136/8</p> <p>director [8] 2/23 2/23 3/21 3/22 65/2 65/3 65/5 72/2</p> <p>directorate [2] 2/25 4/15</p> <p>directors [6] 12/8</p>	<p>64/13 176/5 182/11 182/13 184/4</p> <p>disabilities [8] 69/6 88/11 89/6 97/2 97/12 97/21 158/3 205/9</p> <p>disability [25] 42/12 54/25 55/11 55/13 75/13 87/19 93/21 93/22 97/5 97/8 97/17 97/19 98/5 98/7 101/4 163/1 163/4 163/5 163/10 163/16 163/20 191/15 193/9 195/8 208/15</p> <p>disabled [12] 54/23 55/10 98/3 158/19 162/24 176/25 201/13 207/4 207/15 207/16 207/18 208/4</p> <p>disadvantages [1] 98/20</p> <p>disaggregate [2] 134/10 208/14</p> <p>disaggregated [1] 190/9</p> <p>discard [1] 59/5</p> <p>discarded [1] 58/18</p> <p>discern [1] 154/10</p> <p>discretion [1] 72/15</p> <p>discrimination [2] 195/11 195/21</p> <p>discuss [1] 104/8</p> <p>discussed [1] 193/7</p> <p>discussing [1] 105/8</p> <p>discussions [8] 24/21 24/21 35/2 46/22 54/13 69/19 87/23 179/2</p> <p>disease [3] 2/3 39/25 171/20</p> <p>diseases [4] 64/15 67/25 103/2 103/8</p> <p>disparities [14] 73/5 86/12 105/1 143/6 145/18 145/19 155/14 156/2 191/17 195/3 198/4 198/11 199/10 202/11</p> <p>disparity [3] 144/4 152/19 158/12</p> <p>dispersed [1] 180/20</p> <p>disquiet [1] 118/24</p> <p>dissemination [1] 194/8</p> <p>distance [1] 195/8</p> <p>distancing [1] 206/13</p> <p>distinct [4] 85/4 111/6 125/19 198/3</p> <p>distinction [1] 97/4</p> <p>distinctly [1] 195/9</p> <p>distinguish [1] 160/15</p> <p>distributed [4] 71/22 72/5 86/21 106/13</p>	<p>distribution [1] 117/2</p> <p>distrust [4] 195/11 196/5 196/6 197/4</p> <p>divide [4] 6/9 14/13 173/3 191/18</p> <p>divided [4] 22/22 70/19 185/15 185/24</p> <p>division [22] 1/15 1/16 1/21 2/7 2/7 2/24 3/3 3/18 6/9 6/10 6/20 6/22 20/8 23/2 41/6 41/7 53/3 53/4 53/18 110/13 126/6 148/10</p> <p>divisions [1] 3/4</p> <p>divisive [1] 165/9</p> <p>do [131] 2/12 3/20 3/23 5/15 5/22 6/22 8/9 8/17 13/20 13/24 15/23 16/14 20/3 20/18 22/14 23/7 34/9 41/3 43/2 43/5 45/13 47/19 52/22 53/1 53/18 54/1 54/8 61/17 62/13 66/10 71/5 74/1 74/2 75/25 80/20 86/13 87/15 90/18 92/22 95/20 95/23 96/6 100/5 103/3 104/22 105/1 106/12 111/9 111/19 112/24 114/18 115/14 115/15 118/25 120/7 120/22 121/6 123/10 123/25 124/13 128/11 131/21 132/6 133/23 135/17 135/22 136/17 136/22 138/21 139/16 140/3 140/17 140/18 140/24 144/18 146/10 146/16 146/18 149/8 150/22 152/10 152/18 157/7 157/8 157/23 158/11 158/20 159/9 160/5 160/14 160/14 160/15 160/16 160/16 161/17 162/2 162/6 162/21 163/14 163/24 166/10 168/25 169/4 169/6 169/13 170/2 172/8 174/16 175/22 178/7 178/13 180/7 180/11 180/25 181/15 182/13 182/18 183/10 184/12 185/17 185/20 192/2 195/6 198/23 199/15 200/19 201/15 202/7 204/7 206/5 207/17</p> <p>Doctor [1] 132/25</p> <p>doctors [3] 90/4 102/12 189/18</p> <p>document [30] 12/24 13/3 13/17 13/20 32/4 32/8 32/12 32/19 51/12 51/14 52/2 78/1</p>	<p>78/17 79/4 81/13 83/7 83/23 117/23 118/1 118/8 118/18 119/3 119/21 120/6 120/21 120/25 121/9 121/11 121/19 122/20</p> <p>documented [1] 181/11</p> <p>documents [3] 28/15 33/10 120/18</p> <p>does [18] 2/5 14/12 47/21 47/22 53/23 55/7 105/19 121/20 136/20 139/16 150/10 171/13 177/17 189/24 194/9 196/4 197/19 197/19</p> <p>does it [3] 2/5 121/20 194/9</p> <p>doesn't [5] 42/6 130/7 139/19 161/16 173/1</p> <p>doing [16] 37/18 37/18 52/21 53/1 60/25 83/21 83/21 95/8 110/22 114/5 120/11 120/15 120/16 128/17 162/4 203/24</p> <p>domain [8] 28/18 30/24 35/13 35/19 36/10 36/13 37/7 37/8</p> <p>domains [1] 111/16</p> <p>domiciliary [1] 113/8</p> <p>dominant [1] 16/18</p> <p>don't [38] 5/24 13/21 29/6 34/21 41/22 55/4 55/6 55/7 60/15 78/18 91/17 104/18 115/2 124/12 124/21 136/12 137/1 152/24 156/3 166/20 167/15 170/4 170/11 174/11 177/9 177/10 177/20 178/11 186/22 190/23 193/18 196/24 197/22 197/25 199/19 200/22 202/16 208/3</p> <p>done [43] 21/2 21/3 29/12 29/12 46/19 46/20 54/1 54/6 54/10 56/6 58/10 73/16 88/7 91/6 91/10 93/11 119/10 123/16 128/10 134/24 145/22 145/25 146/2 149/17 151/6 154/1 155/6 155/6 155/24 156/6 169/23 171/12 175/23 177/1 180/15 184/20 194/3 195/1 195/17 199/15 201/13 201/15 201/16</p> <p>Donna [1] 3/22</p> <p>Donna Bell [1] 3/22</p> <p>Donnelly [6] 110/8</p>
--	--	---	---	--

D	Dr Edward [1] 145/1	61/2 70/9 72/22 74/1	157/24 166/14 166/18	encouraged [1]
Donnelly... [5]	Dr Heather [1] 74/15	75/3 77/7 77/12 78/13	172/19	104/8
110/12 110/16 116/7	Dr Kasstan-Dabush [8] 15/13 143/13	81/18 83/13 96/17	efficiently [3] 67/21	end [24] 19/19 22/25
116/23 120/13	155/1 156/25 161/4	118/15 119/15 126/24	127/6 162/6	32/2 43/21 47/10
door [4] 49/22 57/10	185/4 190/1 191/22	136/20 147/6 147/13	effort [2] 106/21	56/17 58/8 58/13
162/13 166/22	Dr Kasstan-Dabush's [1] 197/1	148/22 151/10 152/3	117/14	58/25 59/2 62/8 75/22
dose [10] 20/12 21/8	DR MITCHELL [2]	152/5 152/11 153/10	efforts [4] 64/8 66/20	81/24 84/16 84/17
75/20 82/13 99/5 99/6	57/22 210/6	157/5 177/7 185/18	121/4 208/6	85/2 107/23 109/4
99/10 99/10 185/18	Dr Naresh [2] 107/11	194/21 198/1 199/8	eight [2] 56/4 127/17	119/13 121/23 133/23
186/7	107/18	204/6	eighties [1] 75/19	170/17 172/18 174/10
doses [7] 14/7 84/17	Dr Patricia [1] 110/8	earlier [21] 33/2	either [5] 55/22 91/18	endorse [1] 176/14
85/2 92/21 187/9	Dr Patricia Donnelly [4] 110/12 116/7	34/13 36/8 57/25	167/4 178/17 205/15	endpoint [1] 29/11
187/16 200/6	116/23 120/13	59/23 62/2 77/17	elapse [1] 18/11	engage [1] 198/20
dosing [1] 28/5	Dr Rahma Abdi [1] 145/5	78/21 98/23 102/23	elderly [7] 10/21 23/6	engaged [5] 54/16
doubly [1] 35/19	Dr Richard [1] 67/25	126/18 148/3 150/3	66/7 76/11 124/19	54/17 81/23 149/11
doubt [3] 22/7 31/25	Dr Sadie [1] 145/1	150/19 151/14 174/7	126/11 186/13	150/12
67/17	Dr Tracey Chantler [3] 142/15 142/18	174/24 175/12 182/3	elected [1] 37/2	engagement [13]
down [36] 8/19 8/24	210/19	201/23 208/23	element [1] 12/10	6/25 52/5 53/8 54/11
14/2 14/12 15/7 15/8	draft [3] 31/17 77/11	early [12] 20/6 20/9	elements [3] 29/17	73/12 76/13 87/20
15/25 15/25 19/16	77/20	21/10 44/17 64/25	148/14 160/11	115/7 146/20 147/2
19/18 23/12 23/21	drafting [1] 19/3	65/21 95/2 114/8	elephant [1] 196/7	177/6 189/16 202/6
44/10 46/3 52/1 52/1	draw [4] 13/15	117/15 118/10 126/5	eligibility [2] 161/10	engaging [2] 52/20
53/2 54/6 60/14 79/7	154/20 159/10 162/19	179/14	164/15	52/24
83/23 84/24 85/22	drawing [1] 154/23	ease [1] 94/3	eligible [3] 166/16	England [66] 13/5
86/10 97/15 98/21	drawn [5] 40/13	easier [6] 8/23 22/7	185/22 200/7	13/15 13/16 13/19
118/4 121/17 122/20	40/16 134/15 189/9	140/14 196/11 199/3	else [1] 104/11	14/5 16/14 16/16 27/6
124/10 149/1 149/2	204/10	199/6	elsewhere [2] 41/22	30/1 35/5 39/8 40/14
163/6 172/4 175/4	drive [3] 6/25 94/3	easiest [1] 160/19	56/6	46/9 47/15 48/7 48/25
175/14	146/20	easily [3] 125/18	emanation [1] 38/23	75/11 75/15 80/23
DPHs [1] 176/4	drive-through [1] 94/3	157/15 161/18	emanations [1]	90/22 91/12 99/13
DPO [1] 163/23	driven [2] 53/11	easy [3] 89/5 139/15	150/9	113/13 147/22 148/3
Dr [56] 15/13 15/13	147/11	154/13	embed [1] 202/6	148/20 149/15 149/15
57/22 63/15 63/17	Drivers [1] 51/20	economic [2] 88/17	embedded [6] 18/21	149/21 149/25 150/4
67/25 74/15 107/11	drop [1] 200/7	197/14	20/19 30/4 151/13	150/6 153/21 155/7
107/13 107/15 107/18	drove [2] 11/10 58/3	Edinburgh [4] 60/16	151/15 202/6	161/6 161/9 163/15
107/19 110/8 110/12	146/20	60/17 143/16 149/5	embedding [2] 153/4	164/9 164/13 164/25
110/16 116/7 116/23	drive-through [1] 94/3	educating [2] 60/3	201/22	165/23 166/4 167/5
120/13 133/2 137/18	driven [2] 53/11	140/18	emergency [3] 66/22	167/16 168/7 168/18
140/2 141/8 141/12	147/11	education [3] 9/10	115/14 202/15	168/24 170/16 170/21
142/14 142/15 142/17	Drivers [1] 51/20	17/5 40/9	emerging [3] 2/19	171/8 172/17 173/2
142/18 142/23 143/11	drop [1] 200/7	educational [1]	85/19 85/23	176/2 176/6 178/25
143/13 144/8 145/1	drove [2] 11/10 58/3	165/13	Emily [3] 33/5 34/14	182/19 182/22 184/1
145/1 145/5 146/4	DRPHs [1] 182/22	Edward [1] 145/1	40/12	187/3 188/1 191/3
155/1 156/25 161/4	dual [2] 167/4 168/13	effect [6] 40/13	Emily Lawson [1]	192/10 200/20 200/23
168/16 170/14 174/24	112/17 137/23 190/22	101/11 101/12 101/13	40/12	207/8 207/10
178/1 185/4 185/14	205/12	136/19 150/6	empathic [1] 101/14	England's [1] 34/17
190/1 190/24 191/22	duplicate [1] 68/21	effective [16] 43/3	emphasis [4] 68/21	English [2] 34/7
195/4 197/1 197/3	54/13 70/6 83/9	54/13 70/6 83/9	99/15 147/18 154/5	166/6
203/3 210/6 210/8	during [14] 4/21 5/5	113/21 115/8 115/11	emphasise [3]	enhanced [6] 83/19
210/13 210/18 210/19	5/5 63/4 67/17 87/13	115/17 116/3 116/18	128/11 128/21 168/9	83/20 102/8 102/24
Dr Ben [3] 142/14	88/5 128/16 132/7	131/21 155/15 157/24	empirical [1] 153/25	102/25 140/13
142/17 210/18	132/17 141/17 162/19	159/1 173/19 202/7	employed [1] 133/25	enormous [1] 41/18
Dr Chada [7] 107/15	182/8 184/9	effectively [10] 22/11	employee [1] 16/4	enormously [1] 40/8
107/19 133/2 137/18	duty [1] 77/25	65/13 108/18 109/22	enable [4] 115/6	enough [9] 23/15
140/2 141/8 141/12	dwelt [1] 186/22	110/21 115/22 123/25	133/21 164/10 170/19	28/16 29/14 54/1 54/6
Dr Chantler [13]	DWP [1] 96/9	160/14 169/24 202/22	enabled [5] 18/6	75/17 91/6 149/12
15/13 142/23 143/11	E	effectiveness [6]	80/12 83/12 83/19	196/9
144/8 146/4 168/16	each [49] 19/11 24/5	101/21 102/2 102/3	152/22	ensure [15] 15/9
170/14 174/24 178/1	24/6 24/8 24/9 28/9	153/9 155/2 202/2	enabling [1] 99/17	16/11 30/3 35/19 43/8
185/14 190/24 195/4	29/24 30/3 32/6 33/13	effects [7] 137/23	encountered [1]	54/3 59/12 68/8 84/14
197/3	33/19 39/19 40/7	138/16 138/20 140/5	168/21	92/10 147/25 177/21
Dr Donnelly [1]	43/11 43/13 45/7	140/11 140/16 140/25	encourage [6] 54/7	184/13 205/17 206/7
110/16	47/17 49/17 52/14	efficiency [1] 192/3	90/15 100/2 133/15	ensuring [9] 11/9
		efficient [5] 156/10	136/3 175/4	24/8 35/21 58/2 61/25

E	et [10] 83/3 101/7 112/2 112/2 118/21 129/7 129/8 139/4 139/5 194/16 et cetera [8] 83/3 101/7 112/2 112/2 118/21 129/7 129/8 194/16 Ethical [2] 74/9 97/6 ethics [2] 95/24 163/24 ethnic [24] 21/21 50/14 86/6 86/9 87/19 88/16 104/25 105/10 105/20 106/3 129/24 130/19 153/18 158/5 159/3 187/4 187/14 188/20 189/9 189/10 190/12 191/18 193/13 197/15 ethnicities [5] 186/24 187/11 187/17 187/20 188/12 ethnicity [12] 19/22 20/4 20/25 21/17 22/16 56/7 83/18 86/6 145/16 154/12 187/7 193/11 ethos [1] 71/19 etymology [1] 13/1 European [1] 105/14 evaluate [1] 153/15 evaluated [1] 202/1 evaluating [3] 153/9 155/12 156/22 evaluation [8] 144/9 146/21 147/3 151/1 153/4 154/5 156/13 156/17 evaluations [7] 153/20 153/24 154/2 155/5 178/12 182/19 201/22 evaluative [1] 154/25 Evans [1] 71/12 even [13] 21/23 29/8 56/15 86/5 98/7 114/11 154/10 179/3 191/4 191/8 198/10 198/14 206/12 evening [3] 32/22 34/17 77/20 event [3] 21/3 75/20 77/1 events [2] 102/15 103/5 eventually [3] 4/14 65/17 78/19 ever [3] 111/22 199/16 199/19 every [15] 28/3 40/18 58/11 58/12 73/15 78/1 84/9 84/10 104/3 104/6 134/19 166/15	191/17 199/16 207/11 everybody [8] 16/21 47/16 56/14 100/11 103/3 104/11 158/9 199/13 everyone [1] 118/16 everyone's [1] 113/23 everything [5] 19/2 28/8 49/21 80/11 206/11 evidence [36] 1/8 15/12 16/25 40/12 48/25 50/11 52/5 52/19 56/24 57/25 59/1 59/23 62/2 65/8 74/3 85/23 104/23 106/20 129/23 135/15 142/21 145/23 150/6 153/25 157/18 164/24 171/25 172/3 173/5 173/10 173/25 182/8 183/18 187/2 189/7 207/10 evidence-based [1] 135/15 evident [4] 43/7 162/8 186/12 198/7 evidently [1] 52/7 evolved [1] 136/9 evolving [1] 138/11 ex [1] 12/9 exacerbated [1] 67/18 exactly [12] 12/5 12/12 17/9 21/22 24/3 32/4 36/17 38/19 49/19 55/15 59/18 85/1 example [54] 8/12 21/11 22/5 23/3 26/18 26/25 29/18 29/25 30/9 43/14 44/1 44/22 46/18 47/3 51/16 59/2 60/17 61/6 61/21 62/2 62/10 62/11 62/13 72/13 72/17 83/14 102/25 106/4 111/25 113/7 113/13 114/14 114/22 126/10 132/13 139/9 147/23 155/7 158/2 158/17 159/3 159/23 161/19 163/15 176/13 186/1 189/9 192/12 192/21 192/25 193/14 195/7 205/23 208/7 examples [4] 26/23 31/7 89/2 131/19 excellent [3] 67/23 73/14 73/14 exception [1] 13/10 exceptional [1] 72/10 exceptionally [1]	31/19 excluded [1] 196/15 exclusion [1] 195/9 exclusively [2] 46/11 166/12 executive [2] 65/3 72/4 exempt [1] 90/22 exemption [1] 15/24 exercise [1] 97/20 exercises [2] 66/11 195/19 exhibit [1] 120/18 Exhibition [1] 48/16 exhibits [1] 64/1 exist [1] 192/18 existed [1] 182/24 existence [5] 2/6 5/2 153/11 173/10 183/19 existing [9] 5/10 40/21 67/4 71/23 72/4 87/18 104/23 198/24 201/6 expand [1] 48/14 expanded [1] 170/19 expect [2] 10/10 166/24 expectations [4] 14/19 15/10 39/22 43/1 expected [4] 17/12 39/11 123/15 186/19 expecting [2] 52/20 58/23 experience [9] 58/6 59/20 61/13 66/23 109/14 110/19 143/22 180/15 185/1 experienced [3] 102/14 110/16 191/14 experiences [2] 73/2 105/13 experiencing [2] 88/14 129/25 expert [5] 15/12 21/4 143/2 143/5 143/8 expertise [6] 103/9 103/16 112/13 116/11 150/3 175/16 experts [5] 21/4 142/12 142/13 144/24 145/4 expired [1] 58/15 expiry [1] 59/6 explain [21] 11/13 21/2 37/17 65/23 70/23 74/25 77/11 79/23 80/19 89/18 94/12 94/15 98/21 110/13 112/18 117/17 118/3 122/21 122/25 126/2 139/13 explained [5] 59/23 67/15 69/12 101/20	136/16 explaining [3] 43/15 138/7 173/13 exploitation [1] 162/13 explore [1] 163/19 exploring [1] 62/12 express [1] 149/8 expressed [3] 74/24 174/25 175/6 expressing [1] 118/5 expression [1] 151/13 extend [2] 12/20 72/24 extended [1] 73/8 extension [1] 4/11 extensive [2] 84/7 122/10 extensively [1] 11/1 extent [13] 5/9 9/18 10/10 10/12 46/11 52/11 123/3 150/22 158/19 158/20 162/10 174/13 180/14 extolling [1] 173/12 extra [2] 81/9 81/11 extracting [1] 194/4 extracts [1] 32/20 extraordinarily [1] 63/1 extremely [18] 28/1 30/9 44/24 73/5 83/12 84/4 87/1 100/3 101/17 106/7 106/10 123/18 140/23 158/2 159/5 188/9 192/19 205/7 eye [1] 146/8
			F	
			face [7] 22/8 140/8 143/25 169/18 193/3 202/23 204/8 faced [2] 134/7 134/8 facet [1] 29/9 facilities [1] 48/11 facility [1] 45/25 facing [2] 120/21 120/25 fact [47] 7/24 10/4 19/11 23/25 30/10 54/24 65/3 75/11 75/18 79/25 84/3 84/13 90/1 90/9 91/10 92/15 93/10 95/3 98/24 102/9 104/7 106/9 115/1 117/19 121/19 123/24 124/8 133/17 147/9 148/9 159/9 161/14 164/17 168/20 168/25 169/11 172/24 173/5 174/24 178/1 179/7 179/19	

<p>G</p> <p>generally... [4] 121/1 158/5 158/20 172/8</p> <p>generous [1] 75/21</p> <p>geographical [7] 60/13 129/14 145/16 154/12 183/12 185/16 191/18</p> <p>get [43] 15/5 20/16 29/11 43/17 44/8 45/12 45/17 49/24 60/16 64/7 78/16 81/24 90/25 94/24 96/14 103/3 110/10 114/19 117/7 117/10 119/10 123/23 124/2 132/2 132/10 132/15 133/8 138/6 139/2 146/25 147/5 149/2 162/6 166/5 166/21 168/8 173/4 173/24 199/16 200/10 200/13 200/22 206/11</p> <p>Gething [1] 36/20</p> <p>getting [19] 52/18 53/5 53/10 54/21 56/25 58/13 60/24 93/11 95/10 107/15 109/7 147/10 154/14 158/10 166/19 167/1 173/7 177/4 189/19</p> <p>Gillian [5] 34/5 63/15 63/17 63/22 210/8</p> <p>give [10] 15/3 17/10 21/15 57/5 59/4 100/17 111/10 128/8 163/10 187/13</p> <p>given [25] 16/8 23/25 29/14 41/18 46/24 50/22 60/2 60/21 61/24 62/3 78/9 80/13 104/23 131/19 136/11 141/2 141/20 143/23 149/24 150/16 174/21 188/12 199/8 199/10 203/16</p> <p>gives [2] 101/15 103/4</p> <p>giving [9] 1/9 75/21 93/1 99/16 142/21 164/18 164/23 198/16 208/8</p> <p>gladly [1] 75/24</p> <p>global [4] 103/5 103/5 103/15 143/15</p> <p>glorious [1] 36/6</p> <p>go [34] 7/7 8/22 9/6 10/4 26/19 32/21 41/23 43/25 46/6 52/1 55/24 60/8 69/25 80/22 83/24 84/2 85/18 94/1 98/21 104/5 128/3 133/10</p>	<p>139/8 151/22 154/3 166/5 177/2 178/17 187/13 189/23 190/23 192/17 196/10 199/21</p> <p>goal [1] 202/17</p> <p>goes [2] 86/11 175/11</p> <p>going [78] 7/18 8/20 9/21 9/24 14/6 17/18 19/3 24/6 28/14 34/19 34/20 43/20 44/8 47/8 50/12 62/7 62/20 66/7 66/7 66/20 68/5 84/19 91/2 94/7 97/15 106/15 108/25 109/2 109/3 109/4 109/25 110/24 112/15 114/15 114/17 114/18 114/23 115/20 117/10 118/8 120/4 121/22 131/20 137/14 139/24 142/12 145/9 145/10 146/4 149/1 149/1 149/2 151/22 153/8 155/21 155/22 156/14 156/22 160/17 166/15 168/7 168/16 169/13 170/3 170/4 170/6 175/14 177/5 179/14 183/16 185/14 186/16 196/8 196/22 203/3 203/4 203/18 206/15</p> <p>Gold [1] 47/5</p> <p>gone [1] 27/4</p> <p>good [20] 1/4 24/3 28/11 47/11 57/6 76/25 84/14 87/12 87/12 87/21 102/22 116/17 122/1 132/2 133/2 135/12 137/18 178/18 194/9 199/2</p> <p>goods [1] 177/17</p> <p>got [20] 15/20 18/7 33/16 44/13 59/17 108/12 115/11 118/16 149/3 160/18 160/18 164/21 166/15 169/11 176/15 179/14 182/22 183/14 203/7 206/13</p> <p>governance [14] 6/12 7/1 9/15 25/2 25/4 25/13 26/12 27/18 71/23 110/24 112/9 116/4 116/17 123/12</p> <p>government [61] 1/16 2/8 2/16 2/17 3/8 3/22 4/10 6/19 7/5 7/18 20/8 23/1 23/15 24/17 28/15 30/13 31/3 32/5 33/11 33/17 37/12 42/7 50/9 52/16 52/23 53/5 54/2 56/2 64/12 65/9 66/19</p>	<p>67/11 72/3 73/17 77/12 78/4 79/11 80/18 84/11 85/21 87/1 87/20 90/13 91/3 96/13 96/15 100/17 100/22 113/15 113/25 147/12 147/13 173/11 176/12 176/17 187/22 195/12 195/23 195/25 197/5 200/24</p> <p>Government's [1] 3/24</p> <p>governments [1] 198/1</p> <p>GP [33] 8/16 11/5 12/3 14/3 14/5 39/3 64/22 81/23 83/14 92/6 92/21 121/24 122/22 122/24 123/9 124/8 128/6 161/9 161/14 162/21 167/5 168/6 168/7 169/8 169/9 169/23 173/6 173/17 173/18 178/5 178/17 180/4 180/22</p> <p>GP practices [1] 169/23</p> <p>GP-led [1] 180/4</p> <p>GPs [34] 5/13 8/15 9/22 10/7 10/10 10/18 10/19 11/1 11/16 12/17 12/19 12/20 13/14 13/19 49/1 64/14 82/10 83/14 92/24 92/25 92/25 94/5 96/10 97/20 124/4 124/17 126/10 128/8 167/12 167/16 168/14 169/4 169/16 172/21</p> <p>gradually [1] 175/25</p> <p>grateful [4] 48/20 106/23 142/16 208/25</p> <p>great [19] 21/1 21/18 22/7 28/9 48/8 56/9 56/12 67/6 106/8 145/23 157/19 174/10 175/8 179/15 193/3 194/3 201/15 204/5 204/7</p> <p>greater [7] 7/13 23/5 43/19 130/8 147/22 179/1 186/18</p> <p>greatly [1] 144/24</p> <p>Green [1] 25/23</p> <p>greeting [1] 49/21</p> <p>grew [1] 87/24</p> <p>Grieve [19] 1/5 1/6 1/10 1/11 8/19 13/3 15/8 17/10 22/18 32/11 32/23 36/3 37/24 41/3 48/7 55/24 57/23 63/1 210/3</p> <p>Griffiths [2] 68/2</p>	<p>71/12</p> <p>gritty [1] 117/9</p> <p>ground [4] 43/8 93/18 147/14 157/8</p> <p>groundwork [3] 109/6 109/9 145/22</p> <p>group [51] 6/11 6/14 9/15 10/20 14/18 16/9 43/25 50/22 55/14 59/25 61/7 61/8 68/25 69/2 69/9 70/14 74/9 74/10 76/19 90/20 94/14 94/15 95/16 95/24 95/25 97/6 99/7 109/15 112/11 112/12 112/12 115/5 116/22 116/23 116/25 117/8 118/5 118/23 126/12 126/14 126/16 129/14 129/20 130/17 131/1 161/23 164/2 179/18 188/12 188/21 189/2</p> <p>group 6 [1] 61/8</p> <p>groupings [1] 88/20</p> <p>groups [87] 21/25 29/20 34/18 39/12 44/22 50/16 51/18 52/24 53/6 53/20 54/3 54/4 54/12 73/7 74/12 75/8 81/21 82/8 83/11 83/22 85/6 85/25 86/6 86/9 87/20 88/10 88/16 88/17 90/11 104/25 105/10 109/8 117/13 124/13 126/23 129/25 130/3 130/22 131/3 131/4 131/8 131/9 132/8 132/9 135/9 154/11 158/1 158/5 158/19 158/22 159/4 161/24 161/25 164/11 169/2 169/5 171/24 176/15 176/22 176/24 176/24 176/25 177/12 177/14 177/24 178/16 178/20 183/2 183/15 186/19 187/4 187/14 188/4 188/25 189/5 189/20 190/13 198/9 198/16 198/21 200/2 200/3 201/1 201/3 205/7 205/25 207/22</p> <p>guardians [2] 46/22 48/3</p> <p>guidance [9] 55/16 55/19 68/25 77/4 95/13 96/16 97/2 97/18 160/1</p> <p>guided [2] 51/8 159/25</p> <p>guiding [1] 138/11</p> <p>Gypsy [5] 54/4 106/3 190/16 193/15 193/21</p>	<p>H</p> <p>H1N1 [5] 150/25 151/2 151/8 151/10 170/11</p> <p>had [222]</p> <p>had a [2] 72/19 125/16</p> <p>had the [1] 23/7</p> <p>hadn't [7] 8/2 20/22 35/2 35/2 54/17 59/3 66/6</p> <p>halal [1] 106/10</p> <p>half [2] 80/7 84/25</p> <p>hampered [1] 173/20</p> <p>Hancock [1] 36/19</p> <p>hand [2] 121/18 197/24</p> <p>handled [1] 123/6</p> <p>handling [2] 11/4 34/7</p> <p>hands [1] 197/8</p> <p>hang [1] 27/4</p> <p>happen [8] 17/23 34/20 61/8 109/4 146/15 167/5 177/21 189/11</p> <p>happened [8] 24/25 39/1 61/24 66/22 70/24 94/23 118/7 160/7</p> <p>happening [10] 16/14 16/15 90/5 94/19 103/15 110/4 111/2 119/6 131/5 132/3</p> <p>happens [3] 139/9 180/23 202/15</p> <p>happily [1] 203/1</p> <p>hard [2] 101/2 155/21</p> <p>harder [3] 35/19 81/9 106/12</p> <p>hardest [1] 91/16</p> <p>harsh [1] 48/5</p> <p>has [41] 10/21 11/22 25/12 25/14 26/2 26/18 33/16 43/6 58/18 59/24 71/25 74/18 90/6 101/1 101/2 101/4 104/18 110/18 111/21 112/16 113/17 114/2 115/4 117/14 117/22 118/16 129/23 130/14 133/13 136/11 139/14 145/22 148/20 165/4 174/11 183/15 187/2 190/3 190/6 195/14 198/18</p> <p>hasn't [1] 190/4</p> <p>haste [1] 82/23</p> <p>have [237]</p> <p>have -- I [1] 73/21</p> <p>have a [1] 103/2</p> <p>haven't [3] 63/19</p>
---	---	---	--	---

H	209/3	historically [1] 111/21	100/20 104/18 105/19	I believe [1] 90/2
haven't... [2] 92/14 169/11	helped [7] 40/8 46/2 64/18 81/4 103/12 103/19 181/6	history [2] 79/15 105/13	108/22 110/6 111/12 112/14 112/18 112/20 114/23 115/7 115/20 117/9 120/3 120/4 122/18 124/1 126/18 138/21 139/4 139/4 139/21 140/19 140/20 141/3 143/25 144/3 144/4 146/24 150/21 153/4 153/12 153/15 154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I can [3] 64/5 108/2 203/20
having [36] 5/9 8/12 12/7 13/13 22/4 23/12 26/15 33/22 37/22 38/17 43/16 56/17 59/5 66/23 73/2 95/24 98/6 101/11 101/14 104/13 130/3 162/5 162/23 166/5 167/4 167/6 169/17 176/3 176/21 176/22 189/19 192/19 198/22 202/13 204/3 204/5	helpful [15] 56/18 78/23 83/12 90/19 93/15 106/7 106/10 113/6 120/23 125/10 125/25 127/9 129/3 156/17 162/15	hit [1] 65/16	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I can't [7] 16/23 23/11 32/4 38/22 56/22 61/20 204/23
HCID [3] 103/4 103/5 103/13	helping [5] 49/22 52/25 57/7 70/15 99/16	hm [5] 70/3 164/7 182/12 185/25 193/25	141/3 143/25 144/3 144/4 146/24 150/21 153/4 153/12 153/15 154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I confused [1] 26/6
he [5] 3/1 3/4 3/12 3/21 116/15	helpline [4] 9/5 42/17 56/10 60/9	holding [1] 105/18	141/3 143/25 144/3 144/4 146/24 150/21 153/4 153/12 153/15 154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I couldn't [2] 91/17 173/8
head [2] 1/16 53/4	hence [1] 49/14	home [26] 10/19 13/10 15/17 16/5 16/8 16/9 45/9 61/14 61/20 66/8 75/18 89/25 90/10 90/10 99/4 100/6 100/9 100/10 121/23 133/20 134/1 134/5 135/21 165/2 181/20 189/11	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I created [1] 6/13
headed [1] 2/7	her [2] 82/25 206/25	Home Office [3] 89/25 90/10 90/10	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I did [3] 2/21 3/9 108/20
heading [2] 13/6 171/3	here [10] 18/17 27/5 81/15 134/9 144/21 152/16 161/20 169/21 187/23 191/16	homeless [2] 158/17 191/13	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I didn't [2] 34/20 35/7
headline [1] 187/1	hesitant [1] 199/13	homelessness [2] 88/14 130/1	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I do [7] 13/24 43/5 74/2 90/18 114/18 178/13 180/7
health [244]	heterogeneous [1] 207/21	homes [32] 10/21 13/4 15/16 15/20 16/6 39/3 44/12 70/2 82/6 99/8 99/18 121/22 123/23 123/23 124/14 125/2 125/6 125/14 125/15 133/9 133/11 133/22 134/8 134/11 134/23 136/7 136/23 164/5 179/9 181/19 189/8 189/13	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I don't [8] 5/24 34/21 91/17 124/12 136/12 137/1 202/16 208/3
healthcare [27] 7/15 7/16 11/17 49/13 50/5 71/24 87/12 87/13 89/21 98/10 104/8 106/5 125/9 129/21 133/16 133/25 148/20 149/4 159/15 159/17 168/25 170/22 183/7 183/14 184/21 194/11 194/25	hidden [1] 96/11	honest [3] 54/13 76/4 77/6	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I felt [1] 114/11
hear [1] 91/17	high [21] 11/7 14/23 15/20 27/23 33/17 44/25 47/11 52/8 53/20 99/3 99/25 100/3 103/2 103/7 136/5 137/7 147/7 151/20 152/2 183/3 192/1	honestly [1] 16/15	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I follow [1] 92/3
heard [16] 40/12 48/25 74/18 113/17 113/22 115/4 117/14 127/7 129/23 144/14 145/23 173/9 174/7 182/7 183/18 185/13	high-level [1] 151/20	hope [5] 63/19 141/23 142/2 142/7 160/22	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I fully [1] 134/6
hearing [3] 59/17 142/13 209/9	high-risk [1] 136/5	horses [1] 28/21	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I had [4] 2/10 70/25 109/20 110/3
heart [2] 8/16 195/3	higher [19] 39/24 40/2 47/13 75/14 95/9 100/6 174/1 174/20 186/13 189/20 198/14 199/11 199/24 200/1 200/10 203/14 205/13 207/23 207/23	hospitally [1] 16/15	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I happened [1] 66/22
heartening [1] 150/14	Highland [1] 43/9	hospitals [1] 82/11	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I have [3] 115/15 137/10 141/15
Heather [1] 74/15	Highlands [6] 10/14 43/14 43/19 44/5 44/25 60/23	hospital-based [1] 126/7	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I headed [1] 2/7
Heating [1] 161/12	highlight [6] 73/22 146/1 168/20 178/14 179/7 185/14	hostile [1] 89/23	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I honestly [1] 16/15
heavy [1] 204/7	highlighted [1] 181/7	hour [2] 84/20 84/25	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I just [11] 56/3 119/17 119/23 120/6 121/11 131/10 168/20 174/4 188/7 189/23 203/25
Heidi [1] 98/23	highlighting [1] 145/12	hours [7] 17/25 19/12 19/20 81/3 96/6 205/23 205/23	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I mean [23] 5/13 16/23 52/8 113/22 113/23 114/4 114/6 118/8 119/3 138/24 140/17 146/13 154/1 164/17 169/6 169/7 170/9 171/7 177/18 178/11 199/18 200/2 203/19
heightened [2] 177/18 205/11	highly [6] 40/15 135/8 162/1 179/13 197/3 197/9	housebound [2] 45/18 123/20	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I may [5] 25/20 50/25 74/5 137/24 145/10
held [6] 65/2 66/14 87/25 108/7 144/2 161/15	him [1] 137/14	houses [1] 45/17	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I mean [23] 5/13 16/23 52/8 113/22 113/23 114/4 114/6 118/8 119/3 138/24 140/17 146/13 154/1 164/17 169/6 169/7 170/9 171/7 177/18 178/11 199/18 200/2 203/19
Helen [1] 145/5	hindered [1] 175/1	how [96] 2/5 11/2 18/13 19/2 21/5 26/1 28/12 29/20 42/7 43/7 43/16 45/24 46/16 50/9 51/9 52/12 54/13 55/8 57/1 57/1 62/12 66/16 74/13 74/13 81/2 82/17 83/9 84/6 94/15 95/20 95/23	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I know [7] 54/11 59/5 64/8 79/3 188/8 188/14 203/23
help [19] 37/16 39/17 48/8 50/2 63/4 74/6 94/2 102/16 107/2 107/3 127/4 141/20 142/9 153/22 162/23 204/10 208/22 209/2	hindsight [2] 54/1 138/3	hospitals [1] 82/11	154/19 155/15 155/17 155/21 156/1 156/2 156/19 156/22 157/23 160/14 160/15 160/16 162/2 163/14 163/24 165/11 169/12 170/12 170/13 173/13 179/23 181/9 181/15 183/11 185/14 187/15 194/17 196/12 196/20 197/10 199/13 200/24	I know [7] 54/11 59/5 64/8 79/3 188/8 188/14 203/23

I	171/13 172/11 173/19 174/15 174/18 175/11 176/2 176/18 177/4 177/13 177/20 178/20 178/25 179/5 180/1 180/9 180/19 181/5 181/12 182/1 182/16 182/25 183/9 183/22 184/2 184/16 185/7 188/7 188/8 188/13 189/14 189/22 190/4 190/17 191/7 194/5 194/12 194/17 195/14 196/11 196/22 198/17 198/17 199/5 200/3 201/9 201/21 202/10 202/13 203/3 203/16 203/18 203/21 204/9 204/14 205/19 206/10 206/12 208/12 I thought [1] 114/24 I took [1] 2/7 I understand [1] 60/19 I viewed [1] 4/11 I want [11] 12/25 18/18 74/17 89/10 92/4 133/17 146/7 152/15 199/21 203/17 205/1 I wanted [2] 110/1 157/12 I was [18] 3/19 14/10 17/2 33/7 66/18 85/13 108/13 109/5 109/7 109/10 109/24 115/18 131/16 139/2 139/11 153/8 174/5 182/19 I wasn't [2] 25/1 136/8 I will [3] 15/7 204/23 208/23 I won't [1] 88/24 I would [13] 28/2 41/9 41/9 69/14 110/25 120/1 124/21 134/18 136/21 152/7 163/22 174/14 206/1 I wouldn't [1] 67/23 I'd [4] 1/14 64/11 109/12 142/15 I'll [8] 8/10 18/7 47/7 99/2 104/22 197/1 197/1 203/19 I'm [47] 13/22 14/6 15/7 18/17 20/9 21/1 21/4 21/5 28/9 32/24 38/22 48/20 55/6 57/23 61/4 61/19 62/23 63/22 68/5 76/4 91/17 91/23 91/23 102/3 113/23 115/20 131/19 133/4 134/13 136/21 142/2 142/4	142/6 142/12 145/9 151/21 153/22 155/21 156/10 177/2 184/1 196/10 203/4 203/16 203/18 205/3 208/25 I've [11] 21/24 22/15 35/20 49/22 59/6 104/19 108/12 115/11 115/12 170/25 203/20 I've agreed [1] 104/19 I, [1] 35/16 I, and [1] 35/16 idea [8] 17/10 57/17 76/25 111/10 119/5 192/22 197/22 206/11 ideally [1] 118/15 ideas [2] 57/16 192/20 identical [1] 91/15 identification [10] 42/15 103/17 161/22 162/10 162/11 162/12 205/19 206/1 206/18 208/11 identified [5] 20/6 55/13 86/1 133/13 161/18 identify [16] 10/18 12/14 12/25 19/2 42/5 42/8 42/10 42/14 96/8 96/13 98/6 131/21 162/3 163/14 164/15 194/22 identifying [8] 11/18 55/9 55/17 96/24 145/13 145/20 146/2 163/11 ie [1] 205/21 if [104] 4/24 7/7 8/22 8/24 9/6 13/23 14/18 16/7 16/9 19/17 22/3 23/7 23/7 23/14 25/20 30/18 32/20 33/23 34/14 35/3 35/23 36/18 41/23 42/20 46/20 46/22 47/8 50/25 52/1 52/19 53/1 55/6 60/2 60/22 61/24 62/9 68/12 68/25 74/5 74/6 75/4 75/7 76/4 76/6 78/20 79/5 79/7 79/9 80/6 81/4 82/2 85/10 85/21 89/15 91/12 91/20 91/21 91/23 91/25 93/23 94/4 96/2 101/3 101/8 102/10 103/3 109/4 112/19 114/18 117/19 117/20 121/17 133/24 137/24 139/16 139/24 142/15 145/10 150/10 150/10 150/15 156/3 158/7 160/11 161/4	161/18 162/17 164/21 167/15 172/12 173/2 177/9 177/15 177/20 183/14 184/1 188/19 189/2 189/3 189/15 194/25 195/1 199/5 208/4 illness [1] 97/23 illnesses [1] 135/25 illustration [1] 39/17 immediate [1] 95/4 immediately [4] 19/17 26/21 42/13 80/24 immensely [2] 32/10 48/20 immigration [5] 88/15 89/13 89/19 91/7 193/18 imminent [1] 13/18 immunisation [23] 5/2 5/4 5/4 8/14 18/10 46/12 50/15 82/18 83/2 144/3 144/18 144/22 150/18 165/24 166/2 167/22 171/22 183/12 184/24 192/9 202/22 204/3 207/6 immunisations [1] 168/4 immunise [5] 68/15 75/8 76/7 82/14 100/9 immunised [3] 83/16 94/21 97/16 impact [13] 4/23 13/14 22/4 29/6 41/18 44/18 56/9 90/19 99/22 101/13 158/16 180/25 189/12 impacting [1] 85/24 impacts [1] 197/17 implement [2] 97/13 97/14 implementation [15] 96/17 111/15 116/20 116/23 117/8 121/14 146/20 147/16 148/1 151/23 157/23 159/1 163/22 175/18 176/7 implemented [6] 8/3 94/10 98/14 111/23 112/15 166/24 importance [7] 4/5 33/22 81/25 151/2 158/11 191/2 204/5 important [61] 12/18 23/14 29/1 29/9 29/12 29/22 37/19 41/19 46/25 48/13 49/15 56/25 60/11 60/14 73/19 79/17 87/1 87/4 101/8 101/17 105/24 106/1 113/6 116/3 119/14 121/2 121/6	121/10 128/21 130/5 132/1 132/9 134/10 135/23 138/15 138/25 139/3 140/22 140/24 145/14 149/9 149/10 160/13 169/14 171/12 174/2 176/10 188/13 189/1 190/5 192/4 195/6 195/16 197/10 200/4 200/18 202/5 203/6 203/11 204/12 208/13 importantly [4] 8/14 14/16 51/21 171/14 impose [1] 145/9 improve [7] 144/3 151/8 153/17 155/24 156/20 177/1 197/21 improved [5] 73/25 132/2 153/5 156/1 193/2 improvement [7] 111/18 115/15 128/25 129/21 153/3 194/18 201/13 inability [1] 36/12 inaccurate [3] 30/12 33/24 35/12 inadvertently [1] 21/14 inaudible [1] 35/7 inception [1] 111/22 incidence [1] 189/12 inclement [2] 44/16 62/2 include [5] 4/21 62/13 137/21 138/6 154/5 included [7] 8/11 17/24 150/3 169/8 170/18 171/14 176/4 includes [7] 1/23 4/23 11/16 22/9 24/4 111/17 202/9 including [10] 64/12 64/19 97/11 97/22 105/13 136/18 176/25 189/18 205/1 205/6 inclusion [6] 21/16 50/20 50/21 85/15 169/1 169/4 inclusive [3] 51/14 96/18 179/18 inclusivity [1] 51/20 incoming [1] 35/1 incorporated [2] 105/3 206/10 increase [5] 4/25 18/3 50/19 51/17 131/25 increased [3] 18/8 154/21 160/2 increasing [3] 17/25 195/15 196/13
----------	---	--	---	---

I	194/4 197/7 207/25	189/7 210/4 210/10	15/16 20/25 25/25	134/13 135/17 137/4
incredibly [11] 18/17	informed [5] 46/22	210/14 210/20	36/13 37/7 37/8 37/9	141/13 141/18 148/22
20/19 49/15 78/4	68/9 77/18 79/13	ins [1] 174/3	43/2 48/17 50/17	161/6 161/10 167/9
78/17 123/11 125/25	102/19	inside [1] 2/13	52/12 55/3 62/21	168/18 173/1 177/25
127/9 129/3 156/17	infrastructure [4]	insights [2] 175/17	65/18 67/7 67/15 68/3	178/2 178/9 178/12
164/13	67/12 79/13 82/16	192/12	69/25 80/1 80/12 84/2	178/14 179/7 183/23
incumbent [1] 25/17	111/8	insofar [1] 145/23	90/1 101/1 105/4	190/10 200/21 201/4
indecision [1] 87/5	initial [7] 2/19 18/13	inspect [1] 71/25	111/20 113/8 114/13	Irish [1] 25/10
indeed [30] 2/21 3/9	21/7 79/3 100/8 124/9	Inspectorate [1]	114/19 117/23 118/12	is [321]
3/19 10/1 17/16 24/23	150/23	71/25	119/1 129/2 133/8	is all [1] 52/7
27/13 27/18 28/2 30/8	initially [10] 6/8	instance [20] 23/11	133/10 134/21 136/25	is the [1] 85/11
35/14 39/1 40/19	47/16 54/24 64/22	24/10 69/4 72/6 75/7	137/15 140/13 147/5	is very [1] 164/23
41/23 45/23 47/9	70/13 103/1 138/7	76/6 80/4 81/3 91/19	147/11 149/21 153/21	ish [1] 113/2
48/24 65/14 67/8	147/16 173/20 178/4	92/19 92/23 93/17	154/14 154/22 165/15	island [1] 43/9
68/11 74/15 82/7 95/3	initiate [2] 72/16	93/23 97/20 98/9	167/16 169/11 169/14	islands [5] 10/15
102/10 109/16 120/9	181/20	101/3 103/18 106/8	169/15 180/1 181/19	43/14 44/5 44/25
140/15 140/19 172/25	initiated [1] 19/1	125/10 168/10	182/14 184/9 192/17	60/23
208/22	initiatives [1] 131/2	Institute [1] 144/14	195/25 200/22 208/24	isn't [4] 120/18
independence [2]	injured [2] 137/20	instructed [1] 57/23	into place [1] 43/2	139/15 202/8 205/15
71/19 112/19	137/22	instrumental [1]	introduce [1] 160/11	issue [36] 28/5 34/2
Indian [1] 187/14	innovated [1] 56/2	127/22	introduction [2]	34/10 35/8 37/5 40/23
indicate [1] 41/12	innovation [2] 56/23	intake [1] 191/6	78/13 102/21	50/13 55/16 59/19
indicating [1] 160/1	57/15	intake-up [1] 191/6	invaluable [1] 77/5	74/17 77/8 85/5 97/7
individual [9] 6/4	innovative [1] 93/1	integrate [1] 192/17	investing [1] 153/21	112/17 113/14 122/25
19/11 52/17 114/17	inpatients [1] 13/11	integrated [13] 11/22	invitation [3] 42/11	123/3 130/24 131/11
123/9 128/6 153/16	input [10] 12/11	11/25 12/4 12/9 82/23	49/4 192/25	131/17 133/12 135/2
173/23 193/10	33/17 67/7 98/18	83/3 112/24 125/5	invitations [1] 94/13	143/7 157/22 157/23
individuals [12] 2/9	108/16 148/16 149/22	125/20 125/22 127/24	invite [1] 156/18	160/4 162/24 163/9
8/13 19/2 45/9 55/12	177/4 184/4 189/19	179/20 182/14	invited [6] 24/20	176/11 181/7 181/8
60/12 87/10 93/24	inputted [1] 21/1	integrating [1]	61/15 61/19 94/15	188/24 194/2 197/9
97/14 105/11 137/21	inputting [1] 111/19	184/23	96/7 157/10	197/23 204/11
138/22	INQ000182538 [1]	integration [3] 113/4	inviting [2] 29/25	issued [3] 40/20
inequalities [12]	85/10	179/23 183/4	94/25	55/19 55/19
50/10 51/11 85/8	INQ000240531 [1]	intending [1] 29/20	involve [3] 77/3	issues [42] 12/24
129/19 130/13 176/11	51/12	intense [1] 73/4	106/1 170/5	28/13 40/1 50/24
176/20 180/24 181/4	INQ000276660 [1]	intensified [1] 65/15	involved [27] 9/19	58/15 67/18 73/23
182/21 195/10 198/8	121/12	interaction [1]	10/12 19/8 53/12	88/14 91/16 94/8
inequality [3] 50/19	INQ000376371 [1]	171/23	71/21 84/10 86/13	99/21 108/17 111/2
158/12 176/3	41/2	interesting [1] 98/23	88/3 101/7 109/5	111/14 115/3 115/14
inequity [2] 86/1	INQ000410079 [1]	interface [1] 125/8	109/7 109/8 109/11	130/8 130/11 130/17
143/17	79/5	International [1] 65/5	111/14 111/22 112/2	132/11 132/14 134/9
inevitably [1] 202/15	INQ000474396 [1]	internationally [1]	112/13 115/18 117/9	137/1 143/17 146/24
infect [1] 100/13	7/3	143/19	146/16 148/6 148/11	164/25 166/18 167/24
infection [3] 45/21	INQ000474476 [1]	interoperability [2]	149/15 150/15 174/13	178/23 189/2 193/9
93/9 135/1	107/22	192/15 193/2	175/15 182/19	195/7 195/10 195/18
infectious [2] 103/2	INQ000477804 [2]	interpret [1] 74/13	involvement [3]	196/1 196/17 197/4
103/8	32/18 117/20	interpretation [1]	150/12 150/19 174/12	197/6 197/24 198/15
influenza [6] 4/20 5/4	INQ000498602 [1]	69/1	involving [1] 141/5	199/7 203/4
86/17 167/10 192/9	31/10	interpreters [1]	Ireland [68] 25/8 27/3	it [422]
198/12	INQ000499465 [1]	201/12	36/21 77/14 108/8	it allowed [1] 80/20
inform [4] 25/18	13/2	interpreting [1] 95/18	108/22 109/16 110/4	it at [1] 168/5
155/10 155/17 160/7	INQ000501330 [1]	interrelated [1] 137/2	110/18 110/25 111/8	it fairly [1] 166/8
informal [2] 4/4 65/9	63/25	interrupt [3] 131/10	111/11 111/13 111/16	IT system [1] 129/1
information [32] 9/8	INQ00498603 [1]	189/23 203/16	111/24 112/7 112/16	IT systems [1] 128/7
21/11 22/10 32/7	36/18	intersectionality [1]	112/21 112/23 113/2	it to [1] 53/13
33/23 35/1 35/20	inquiry [32] 1/7 10/3	197/20	113/3 113/16 113/21	it's [111] 3/23 4/7
37/12 37/15 82/24	10/5 15/12 22/18 46/9	interval [2] 28/6 69/5	115/3 115/21 116/21	8/22 12/18 13/22
89/3 89/4 89/9 89/12	50/11 63/5 63/18	intervening [1]	119/20 120/3 120/10	13/23 20/19 21/1 21/6
91/2 91/2 99/16	63/23 74/18 107/3	118/13	120/17 122/8 122/22	22/13 23/13 26/14
103/21 104/4 120/16	107/14 107/20 113/17	intervention [3]	123/10 124/11 127/10	26/20 30/21 38/23
120/23 121/16 128/18	115/4 117/14 120/19	112/6 121/3 154/19	127/25 128/2 128/13	38/23 39/19 41/19
132/11 155/19 155/23	129/22 141/14 141/21	interventions [3]	130/4 130/10 130/10	45/4 46/17 47/25
156/8 161/15 168/12	142/19 142/21 156/18	54/14 153/5 201/24	130/18 130/25 131/16	47/25 50/4 52/7 58/6
	169/12 171/25 181/1	into [59] 6/14 12/11	132/17 132/20 133/4	58/17 59/20 60/11

I	26/15 26/22 26/24 27/3 27/10 27/16 27/18 38/10 39/12 40/18 40/18 46/24 51/6 55/4 68/20 68/25 69/14 73/10 73/12 73/15 74/13 94/10 94/13 97/1 97/14 97/18 157/2 157/6 157/15 158/7 158/15 165/11 205/6 JCVI's [2] 95/18 158/21 Jeane [4] 3/11 3/13 31/14 36/19 Jeane Freeman [3] 3/11 3/13 31/14 Jeremy [2] 68/2 71/12 jetsam [1] 35/17 Jewish [3] 106/11 193/16 199/1 Jill [1] 82/25 job [5] 29/8 45/4 45/11 85/14 102/18 join [2] 149/23 194/21 joined [2] 3/21 65/9 joining [1] 40/22 joint [8] 11/22 11/25 29/15 66/12 77/15 117/15 117/23 117/25 jointly [1] 117/16 joyous [1] 57/13 July [1] 115/24 July 2020 [1] 115/24 jump [1] 156/12 June [10] 2/18 3/19 65/21 70/14 70/19 70/24 88/3 99/4 187/19 188/1 June 2020 [4] 2/18 3/19 65/21 70/14 June 2021 [2] 70/19 70/24 June 2022 [2] 187/19 188/1 junior [1] 102/12 jurisdiction [1] 155/17 jurisdictions [1] 160/5 just [92] 3/4 7/7 8/19 8/22 8/24 11/13 12/3 18/7 20/16 20/24 21/22 27/7 30/16 31/7 37/13 44/1 44/19 51/16 53/2 53/13 56/3 63/24 64/11 69/11 70/23 70/23 79/9 81/11 81/15 84/25 88/8 89/10 92/4 92/20 98/9 103/21 105/15 107/21 110/4 110/13	117/19 118/6 118/22 118/25 119/17 119/18 119/23 120/6 120/6 121/11 124/4 124/23 124/24 126/14 126/17 131/10 131/16 132/25 137/24 139/11 140/1 140/18 143/8 159/14 168/2 168/20 170/16 171/2 174/4 174/9 177/18 185/14 185/21 186/3 186/25 187/23 188/7 189/23 189/23 190/5 193/1 196/22 197/22 199/18 199/23 201/4 202/13 203/4 203/25 203/25 205/14 208/12 Justice [1] 133/5 justify [1] 157/16	kinds [1] 91/14 Kingdom [23] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 56/6 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25 knew [8] 16/8 35/6 50/15 66/6 86/19 94/5 96/8 98/7 know [170] 16/14 20/3 34/19 34/20 35/7 38/12 38/16 47/8 54/11 58/24 59/5 59/6 60/15 60/24 64/8 72/10 72/19 77/24 78/15 79/3 80/3 84/24 87/8 87/18 87/22 91/8 91/10 91/11 92/15 92/15 92/20 92/22 93/1 94/1 95/4 99/13 100/2 101/7 101/10 101/16 102/13 103/13 103/16 104/2 104/18 106/15 109/1 109/8 109/11 109/24 109/24 110/23 111/7 111/17 111/17 111/21 111/25 112/7 113/7 113/8 113/10 113/12 114/1 114/2 114/7 114/21 116/2 116/7 116/12 116/14 118/9 118/11 118/19 118/24 119/1 119/3 119/6 119/7 119/9 120/9 120/12 121/4 121/5 121/7 121/7 122/12 122/17 123/4 123/21 124/19 124/24 125/11 125/16 126/10 126/19 126/21 126/22 127/20 128/8 128/23 129/6 129/11 129/13 129/14 129/17 130/8 130/11 130/12 130/22 130/23 131/4 131/7 132/4 132/12 133/6 134/16 134/18 135/2 135/4 135/8 136/5 136/7 136/9 138/25 139/6 139/23 140/22 143/3 150/14 152/20 152/24 155/13 156/3 161/20 162/3 162/17 162/20 165/1 167/15 167/24 168/7 169/22 170/4 170/10 170/11 176/16 177/9 177/11 177/16 177/20 182/4 182/23 183/1 188/8 188/14 189/16 189/21 193/16 194/12	194/14 195/21 195/22 196/18 196/24 199/2 199/5 200/6 202/8 203/23 206/10 knowing [3] 126/10 129/13 183/13 knowledge [4] 134/19 167/14 176/15 184/25 known [6] 22/20 96/10 120/14 144/13 198/9 207/6 knows [1] 103/3 Kumar [1] 107/18
J	jab [1] 59/4 jabs [1] 59/3 Jack [1] 145/2 January [19] 1/1 2/18 28/24 30/11 33/20 34/1 34/5 36/13 36/20 38/6 38/23 77/13 79/1 81/25 82/10 83/7 117/16 118/12 123/17 January 2021 [4] 28/24 30/11 38/6 117/16 jargon [1] 192/14 JCVI [46] 16/25 17/21 18/24 18/25 19/6 25/11 25/12 25/14 25/15 25/21 25/25 26/9 26/12	Kasstan [14] 15/13 142/14 142/17 142/22 143/13 155/1 156/25 161/4 185/4 190/1 191/22 197/1 203/3 210/18 Kasstan-Dabush [5] 142/14 142/17 142/22 203/3 210/18 KC [4] 57/22 133/1 210/6 210/15 keen [4] 37/14 97/14 109/24 147/25 keep [3] 93/20 137/14 179/12 keeping [3] 79/13 102/18 159/12 Keith [5] 1/3 9/21 57/19 161/1 204/19 kept [4] 58/17 63/19 104/10 169/4 key [16] 29/17 70/10 79/8 79/10 112/14 112/22 116/6 146/15 151/1 171/7 176/2 182/1 182/25 185/7 195/16 201/7 key relationships [1] 201/7 kind [30] 68/23 112/17 112/19 120/22 129/23 151/16 151/20 154/19 155/5 155/10 171/17 173/23 173/24 174/18 174/20 175/23 175/24 176/19 176/21 177/5 177/7 180/9 181/14 192/20 193/19 196/19 196/20 197/24 198/18 206/12 kindly [1] 55/25 kindred [1] 28/11	labour [1] 197/12 lack [8] 29/3 73/1 90/16 184/21 197/4 197/13 198/19 207/17 lacked [1] 91/1 lacking [1] 198/18 lady [17] 1/4 10/4 14/15 57/18 62/23 63/6 63/14 82/25 107/11 136/11 137/17 141/9 142/13 143/3 155/22 160/20 208/19 lag [2] 94/23 166/7 land [1] 57/1 landed [1] 57/9 language [4] 77/25 101/19 167/25 195/8 languages [2] 89/3 201/10 large [18] 9/17 11/3 12/14 46/11 49/3 52/11 84/23 85/3 127/2 127/12 127/19 139/24 158/18 162/9 169/10 173/22 186/17 198/1 largely [2] 20/22 109/21 larger [3] 122/10 126/7 173/24 Larson [1] 98/24 laser [2] 11/9 58/2 last [1] 84/25 lastly [1] 56/19 late [6] 4/24 36/13 65/8 77/18 127/17 170/1 later [12] 4/16 5/16 26/20 36/8 44/8 69/10 83/17 124/4 173/16 174/12 175/21 178/22 latter [3] 4/7 47/25 146/18 Latterly [1] 17/3 laudable [1] 52/7 Lawson [1] 40/12 lay [1] 41/24 layers [1] 91/14	

L	58/23 118/12 184/6 189/4 191/3	limitations [6] 177/22 178/23 192/21 193/15 193/15 207/13	logistical [4] 9/4 10/23 48/8 149/4	143/18 187/4 187/11 188/4 188/5 190/12 193/16 196/15
laying [1] 109/9	lessons [3] 22/15 131/22 160/5	limited [6] 10/7 14/7 14/22 155/11 155/20 159/22	logistics [4] 70/1 79/18 117/4 174/15	lower-levels [1] 187/11
lead [12] 1/7 3/18 65/19 66/18 71/9 108/19 110/8 142/19 144/13 196/2 210/4 210/20	let [1] 91/7 let's [7] 7/3 31/7 32/19 53/2 148/7 166/13 166/16	line [2] 42/25 73/9 lined [1] 116/18 lines [1] 146/17 linked [1] 19/15 links [2] 151/9 189/6	London [13] 30/12 40/13 76/9 99/12 130/8 143/14 144/10 144/19 144/25 145/3 145/5 149/5 152/4	lowest [1] 99/8 lowly [1] 99/18 ludicrous [1] 164/20 luxury [2] 81/11 87/16
leader [1] 110/17	letter [2] 31/14 36/18	list [12] 16/21 16/22 39/9 40/16 59/10 88/24 89/10 89/11 158/7 161/3 162/1 205/6	long [7] 13/11 58/17 58/18 81/2 96/20 115/11 172/4	M
leaders [2] 87/17 106/7	letterboxes [1] 57/2	lists [1] 84/17	longer [3] 104/11 119/12 205/24	MACA [1] 127/13
leadership [3] 71/23 72/5 135/18	letters [1] 57/8	literally [2] 14/24 57/2	longer-term [1] 119/12	made [31] 13/23 16/11 24/2 29/7 30/24 34/12 34/22 35/12 36/15 43/25 61/21 63/24 64/9 66/15 69/3 82/18 90/19 107/21 117/22 133/19 134/19 151/21 152/19 158/5 158/19 158/25 169/16 180/6 184/15 193/4 200/12
leading [3] 21/6 52/23 108/24	level [54] 5/3 5/3 11/7 12/11 14/23 20/23 21/22 21/23 21/23 21/23 23/8 29/10 33/11 33/17 34/11 34/11 42/24 45/5 52/8 54/2 54/2 100/3 100/6 109/8 111/2 119/6 119/23 134/15 143/18 148/16 148/19 149/3 151/20 151/24 154/9 155/8 162/21 162/22 174/21 174/25 175/17 176/4 176/21 176/22 177/7 177/8 185/11 188/21 189/20 193/17 199/10 200/5 202/23 203/14	live [4] 20/2 60/18 142/6 158/17	longstanding [1] 114/1	Mail [1] 57/7
leads [7] 2/9 2/11 2/11 2/12 5/20 27/10 84/10	levels [14] 62/10 84/4 154/10 155/23 174/1 184/3 185/13 187/11 189/12 195/11 196/6 199/11 199/24 200/1	lived [3] 60/1 86/2 86/3	look [43] 7/3 7/12 8/24 12/25 31/7 35/23 36/18 37/24 38/21 39/23 40/24 66/3 71/3 74/3 76/4 79/5 81/14 82/2 83/12 83/17 83/20 84/21 85/21 117/19 120/7 121/11 145/15 145/17 148/7 151/22 154/10 155/8 155/22 156/14 160/17 168/16 186/25 189/25 191/22 194/15 196/12	main [6] 19/13 161/19 170/15 194/20 202/20 204/1
leaflet [1] 104/4	liaised [1] 90/3	liver [1] 171/20	looked [3] 27/17 131/4 165/11	mainstay [1] 20/20
leaflets [2] 9/14 201/10	liberal [1] 55/11	Liverpool [1] 30/23	looked at [2] 27/17 131/4	mainstreaming [1] 71/4
league [1] 47/18	licence [1] 16/3	lives [2] 60/15 195/25	looking [8] 76/11 88/4 96/5 120/4 131/21 135/11 154/3 154/19	maintain [4] 29/13 67/4 164/9 172/14
learn [5] 103/14 103/20 155/16 160/5 177/22	life [3] 75/13 75/23 190/6	living [1] 112/8	loads [1] 57/13	maintained [3] 84/3 97/20 140/4
learned [2] 22/15 131/23	lifestyle [1] 93/19	Lleyn [1] 92/24	loan [1] 65/13	Maintaining [1] 138/10
learning [39] 54/25 55/11 55/13 66/12 69/6 72/11 88/11 93/21 93/22 97/2 97/5 97/8 97/11 97/19 97/21 98/2 98/4 98/7 103/12 116/3 150/24 151/13 151/25 156/11 158/3 163/4 163/5 163/10 163/16 165/6 178/21 182/1 182/25 188/14 193/9 205/8 205/9 206/9 206/14	lift [1] 158/9	Lleyn Peninsula [1] 92/24	local [38] 11/23 22/1 39/4 40/11 42/1 47/23 47/25 47/25 48/23 51/24 53/6 53/6 53/6 61/3 71/15 71/16 81/19 83/14 96/9 96/17 96/18 96/20 113/13 148/2 149/3 153/23 161/14 162/21 174/25 175/3 175/17 176/1 176/17 176/22 177/8 177/16 184/22 198/2	major [8] 61/5 115/2 121/3 129/1 175/7 188/22 188/24 201/9
least [22] 5/3 16/22 36/13 41/15 48/14 58/25 59/24 86/4 94/14 96/4 119/4 136/1 139/19 147/7 147/11 165/13 185/18 186/6 187/17 187/22 191/10 199/9	lifting [1] 204/8	local/regional/nation al [1] 177/8	looks [1] 100/23	majoring [1] 195/5
leave [3] 52/10 72/18 203/21	lights [1] 181/8	localities [1] 132/3	loose [2] 142/4 142/6	majority [1] 17/13
leaving [2] 53/13 86/20	like [29] 1/14 11/9 21/25 48/4 58/2 62/25 64/11 70/1 81/4 91/11 113/7 117/1 121/3 122/12 123/21 127/8 130/6 130/21 132/14 145/17 149/1 160/11 172/13 176/18 186/2 196/7 196/17 199/19 199/20	locally [2] 6/6 53/17	lose [1] 160/12	make [55] 15/4 22/11 23/24 34/16 45/25 48/1 48/4 52/9 76/3 79/12 81/10 84/12 84/22 93/3 93/9 93/10 94/2 100/12 106/13 110/2 110/4 110/20 110/22 112/9 119/13 130/6 135/14 135/24 136/3 136/5 137/5 137/13 140/16 140/25 147/4 153/1 155/25 156/20 162/6 167/2 168/2 169/20 170/17 172/19 174/15 184/12 189/22 195/6 197/11 203/2 203/6 203/12 204/13 205/21 208/23
lecturer [1] 143/15	liked [3] 53/21 118/17 180/10	located [1] 174/1	lost [1] 137/23	makes [3] 132/12 154/4 189/14
led [18] 6/2 6/5 6/6 7/10 7/22 48/18 53/16 59/24 68/17 68/19 73/3 96/22 98/25 113/15 116/23 167/11 178/4 180/4	likely [6] 18/25 41/14 42/8 46/6 66/9 205/11	location [1] 185/16	lot [22] 37/20 43/13 54/9 54/18 110/18 112/14 113/22 114/12 120/15 122/5 127/5 128/24 129/9 129/23 132/6 132/16 135/17 154/3 174/7 180/21 183/10 189/16	making [17] 48/9 53/8 55/9 59/15 59/15
left [2] 98/1 104/19	likewise [2] 42/20 48/12	locations [3] 174/19 201/2 205/21	lots [7] 20/11 22/15 121/16 131/1 131/2 164/14 165/6	
legislation [2] 41/20 148/15	limbs [1] 52/2	lockstep [1] 61/9	low [9] 84/4 123/6 129/19 130/17 130/18 130/23 131/1 132/8 188/10	
lengthy [1] 143/2	limit [1] 199/14	logical [1] 135/15	lower [15] 52/19 62/10 104/24 106/16 130/1 130/3 131/24	
less [7] 12/15 19/20	limitation [4] 194/12 207/18 208/2 208/5	logistic [1] 148/24		

M	maternal [1] 196/16	means [5] 25/20 25/23 84/18 90/14 114/10	message [7] 33/2 34/14 59/16 90/25 105/16 105/24 160/19	miniscule [1] 101/10
making... [12] 61/4 61/11 73/13 98/24 105/4 109/21 135/3 147/19 151/3 151/17 171/21 182/3	maternities [2] 91/11 91/19	meant [9] 35/18 57/9 77/21 77/24 79/23 80/22 80/23 118/5 166/6	messages [4] 59/11 59/19 139/17 151/5	minister [9] 3/10 26/13 31/14 32/24 33/6 34/16 57/4 97/25 116/16
man [1] 81/4	maternity [2] 91/22 91/24	measure [1] 177/12	messaging [10] 22/2 29/24 52/9 105/22 137/25 138/21 139/15 140/5 147/10 189/22	ministerial [1] 98/16
manage [1] 68/7	Matt [1] 36/19	measured [2] 15/1 18/12	messenger [2] 105/25 106/5	ministers [13] 3/7 3/15 4/10 4/12 4/23 13/24 25/10 25/19 34/8 37/14 47/9 51/5 114/7
managed [5] 15/23 19/5 22/14 115/23 178/4	matter [15] 18/24 25/7 26/11 50/4 78/15 100/16 100/21 124/23 156/7 157/2 177/18 189/24 190/6 197/19 197/20	measures [2] 129/24 131/23	met [2] 17/16 115/24	minorities [3] 130/19 189/9 189/11
management [10] 9/5 19/14 84/21 103/20 128/2 128/12 128/15 128/22 192/9 207/6	matters [9] 28/8 63/24 69/15 70/5 89/10 102/4 107/21 117/1 117/6	meat [1] 131/8	method [1] 156/3	minority [20] 21/21 50/14 86/5 87/19 88/16 104/25 105/10 105/20 106/3 129/25 143/18 153/18 155/14 158/5 159/3 187/4 187/18 188/20 190/13 197/16
managing [1] 9/7	matured [1] 129/10	mechanism [4] 77/5 79/22 103/6 106/14	methodology [3] 113/24 114/2 124/1	minus [1] 38/18
mandatory [2] 98/25 135/3	maximising [1] 126/24	mechanisms [2] 71/24 154/20	methods [4] 122/8 145/18 154/23 191/23	minus 70 degrees [1] 38/18
manifested [1] 198/8	maximum [2] 35/4 39/18	media [5] 30/19 37/2 51/24 57/13 121/8	MHRA [10] 16/25 38/10 40/19 68/20 74/5 80/7 101/23 102/9 102/18 141/1	minute [6] 18/2 69/5 104/10 104/15 119/24 120/6
manner [1] 163/25	may [42] 1/18 21/16 25/20 26/25 26/25 29/4 32/2 33/5 41/13 42/23 45/14 48/6 50/10 50/25 69/7 74/5 83/21 85/1 88/13 91/1 93/10 96/10 99/20 99/21 101/10 102/10 102/13 121/12 121/19 125/21 136/12 137/24 138/3 140/7 145/10 150/6 150/10 161/17 161/20 162/23 174/10 202/11	medical [19] 2/14 64/21 65/11 67/1 67/14 74/15 87/2 100/1 108/4 108/7 108/10 108/14 108/18 109/10 116/6 116/14 120/13 127/16 135/18	Michael [1] 133/13	minutes [1] 18/3
mantra [1] 53/16	may 2019 [1] 1/18	medicine [5] 64/25 108/13 143/15 144/10 145/1	microphone [2] 104/21 137/15	minutiae [3] 53/12 147/5 200/22
many [22] 12/20 12/24 15/2 15/4 32/16 42/8 53/15 53/21 59/11 68/15 84/13 92/13 96/10 102/11 121/16 133/6 133/18 136/3 136/18 137/5 143/22 197/11	May 2020 [1] 150/10	Medicine's [1] 144/20	mid [3] 13/18 17/11 73/8	misinformation [2] 139/20 197/7
map [2] 102/15 145/9	May 2021 [1] 45/14	Medicines [1] 15/25	mid-December [1] 13/18	misrepresentation [1] 35/18
March [8] 17/11 51/13 58/22 85/16 88/1 108/9 108/15 127/17	maybe [6] 15/7 27/13 84/24 85/1 132/13 149/2	meet [2] 14/20 146/21	mid-December 2020 [1] 17/11	mission [3] 68/12 68/13 68/14
March 2019 [1] 108/9	McBride [1] 133/13	meeting [3] 49/21 73/15 88/1	mid-February [1] 73/8	mistrust [4] 53/25 105/8 105/12 105/19
March 2020 [1] 108/15	McGowan [1] 73/14	meetings [13] 24/22 27/3 27/16 67/6 72/23 76/15 76/22 77/2 90/5 90/9 90/9 115/4 149/22	middle [2] 26/19 81/4	mistrustful [1] 132/13
March 2021 [2] 58/22 85/16	me [16] 21/5 41/4 44/13 61/12 87/5 87/6 87/7 110/9 115/16 134/10 164/18 184/1 190/4 192/14 199/23 203/21	member [7] 26/16 73/20 74/2 96/4 104/6 134/5 150/7	might [37] 18/11 20/16 40/2 40/3 42/6 43/22 57/1 62/13 73/24 74/13 75/25 76/25 89/15 89/20 91/8 91/20 93/6 93/12 102/25 103/12 114/11 130/1 131/21 131/23 141/3 146/11 148/11 154/20 156/6 160/4 160/6 162/13 186/19 195/19 199/12 202/3 206/3	misrepresentation [1] 35/18
marginalisation [1] 197/15	mean [38] 2/12 5/13 14/12 16/23 20/21 22/2 22/2 29/4 47/19 47/22 47/22 52/8 61/17 62/20 113/22 113/23 114/4 114/6 118/8 119/3 138/24 140/17 146/13 154/1 164/12 164/17 169/3 169/6 169/7 170/9 171/7 177/18 178/11 192/6 198/7 199/18 200/2 203/19	members [15] 6/19 12/9 27/9 54/4 58/6 88/15 93/14 97/9 97/11 102/11 105/10 133/6 133/8 133/18 133/22	migrant [3] 90/11 130/22 193/22	misrepresentation [1] 35/18
marginalised [8] 50/14 54/4 153/18 155/25 158/6 179/24 180/8 200/5	mean 2021 [2] 58/22 85/16	membership [1] 169/1	migrants [2] 54/4 129/25	mission [3] 68/12 68/13 68/14
marketing [4] 18/5 51/22 57/10 139/8	marginalisation [1] 197/15	memorandum [2] 80/14 80/17	mild [2] 97/5 98/8	mistrust [4] 53/25 105/8 105/12 105/19
marshal [1] 49/22	marginalised [8] 50/14 54/4 153/18 155/25 158/6 179/24 180/8 200/5	memory [1] 112/8	milestones [1] 78/16	mistrustful [1] 132/13
mass [22] 5/17 39/5 48/17 61/15 62/1 66/24 81/16 82/11 84/13 93/6 121/24 122/10 127/4 127/10 139/25 155/22 171/3 173/17 178/4 205/4 205/11 205/22	mass [22] 5/17 39/5 48/17 61/15 62/1 66/24 81/16 82/11 84/13 93/6 121/24 122/10 127/4 127/10 139/25 155/22 171/3 173/17 178/4 205/4 205/11 205/22	mental [3] 88/13 97/23 163/1	military [10] 48/6 48/7 48/12 48/18 48/19 64/20 127/1 127/9 127/13 127/15	misrepresentation [1] 35/18
massively [1] 17/22	mass [22] 5/17 39/5 48/17 61/15 62/1 66/24 81/16 82/11 84/13 93/6 121/24 122/10 127/4 127/10 139/25 155/22 171/3 173/17 178/4 205/4 205/11 205/22	mention [4] 45/7 56/4 81/25 82/3	million [3] 18/7 39/12 101/10	misrepresentation [1] 35/18
match [1] 34/23	massively [1] 17/22	mentioned [7] 10/22 18/20 59/6 80/14 159/5 206/1 207/7	millions [1] 194/7	misrepresentation [1] 35/18
matches [1] 46/4	match [1] 34/23	merits [2] 32/23 33/10	mind [6] 23/2 33/21 44/11 105/18 138/21 194/10	misrepresentation [1] 35/18
material [8] 9/11 10/3 10/5 19/4 19/5 29/6 51/22 208/24	material [8] 9/11 10/3 10/5 19/4 19/5 29/6 51/22 208/24		minimum [3] 16/11 68/16 156/16	misrepresentation [1] 35/18

M	122/12 124/19 125/17 125/18 126/11 128/4 132/9 132/10 132/18 133/9 135/22 138/4 138/9 139/12 139/23 140/18 150/3 153/4 154/4 154/5 155/7 157/8 161/18 168/11 171/14 172/12 172/25 173/6 173/13 180/11 180/20 184/19 184/21 186/12 189/1 189/2 190/21 191/1 191/3 196/19 199/20 201/16 201/19 206/4	Mr Keith [5] 1/3 9/21 57/19 161/1 204/19 Mr Wagner [2] 204/21 206/23 Mr Weatherby [2] 204/18 204/20 Mr Weaver [2] 137/12 141/10 Mr Wilcock [3] 132/25 136/14 137/10 Ms [13] 57/3 57/21 62/24 63/13 104/17 104/18 107/10 132/24 206/24 206/25 207/2 208/20 210/23 Ms Beattie [2] 206/24 208/20 Ms Freeman [1] 57/3 Ms Mitchell [2] 57/21 62/24 Ms Stephenson [5] 63/13 104/17 104/18 107/10 132/24 MSP [2] 3/11 3/12 much [64] 1/11 7/8 11/11 11/21 18/22 32/21 34/4 36/1 37/14 55/19 58/4 62/12 62/24 63/3 63/6 64/10 71/13 76/3 86/21 98/8 104/10 104/17 104/18 106/12 106/19 107/2 109/11 113/9 114/21 114/22 117/9 119/13 125/17 125/18 126/11 129/4 129/12 129/16 132/24 134/4 136/22 137/9 138/24 141/10 141/12 141/16 142/9 142/25 145/22 148/3 155/6 166/3 167/20 178/12 182/18 186/13 190/7 195/24 196/5 197/24 204/20 208/20 208/22 209/2 multiple [1] 33/9 Muslim [1] 106/8 must [1] 13/17 my [59] 1/4 1/10 2/23 2/24 3/21 4/11 10/4 14/15 14/15 18/18 20/7 22/12 26/3 32/24 47/2 57/12 57/18 57/20 59/19 60/20 62/23 62/23 63/6 63/14 64/11 71/10 87/6 100/22 104/16 105/12 105/18 107/11 107/18 110/21 114/4 115/16 119/12 132/23 133/6 134/16 134/19 136/11 137/3 137/17 137/18 138/19 140/3 141/9 142/13 143/3	145/9 150/19 155/22 160/20 164/18 167/14 190/3 207/16 208/19 my Lady [6] 1/4 10/4 14/15 141/9 142/13 208/19 myself [2] 26/6 110/7	145/25 146/16 151/20 168/9 169/9 171/13 171/14 172/7 176/20 177/2 179/11 186/22 190/23 192/24 195/19 196/1 196/14 196/23 200/22 202/21 208/11 208/17 needed [24] 23/6 23/17 29/12 37/20 52/22 69/1 71/3 72/7 73/23 81/6 84/19 85/1 93/24 96/2 99/15 100/11 102/8 102/24 103/24 114/6 116/11 173/24 175/14 177/22 needing [1] 97/13 needn't [3] 55/24 69/25 83/24 needs [16] 27/17 74/2 100/24 100/25 101/1 102/20 114/17 128/17 154/17 154/21 181/11 195/16 196/2 200/12 200/17 205/25 negotiate [1] 169/10 negotiated [1] 169/12 negotiating [1] 169/18 nervous [2] 75/16 91/12 network [2] 14/4 169/25 networks [8] 30/1 83/14 87/18 169/23 171/1 172/17 172/19 173/2 never [4] 23/24 89/22 89/25 90/1 nevertheless [3] 24/20 31/23 119/3 new [11] 8/12 8/12 17/24 21/11 40/22 93/2 93/2 129/1 168/11 198/14 198/15 news [1] 57/6 next [14] 22/6 22/8 59/19 61/23 63/14 94/13 94/24 107/11 146/3 169/18 170/4 204/8 204/21 206/7 NHS [30] 7/10 7/12 7/14 7/23 9/1 9/3 9/6 9/10 16/2 16/4 40/9 49/1 64/12 65/2 68/2 72/4 82/16 91/15 92/7 92/13 148/20 148/21 148/21 149/25 153/21 176/6 182/22 192/24 193/19 207/10 NHS England [6] 148/20 149/25 153/21 176/6 182/22 207/10
			N	
			name [7] 1/9 1/10 63/21 107/17 107/18 137/18 195/22 names [1] 142/21 Naresh [4] 107/11 107/13 107/18 210/13 nation [11] 23/4 24/6 26/2 33/16 73/21 77/12 90/7 152/6 157/5 179/8 191/4 national [24] 9/1 9/3 9/10 21/22 22/1 40/9 42/17 50/21 53/16 71/15 82/24 84/1 87/11 90/5 144/13 171/8 173/11 176/21 177/8 179/17 192/8 193/11 207/5 207/11 national-level [1] 176/21 nationally [3] 6/2 6/5 6/6 nations [47] 22/22 24/20 28/10 29/18 30/4 31/18 34/7 34/12 35/15 67/6 69/18 74/1 74/7 76/14 77/8 78/8 78/13 78/18 115/5 117/17 117/18 121/17 121/17 125/8 145/21 147/6 147/13 147/19 151/4 151/11 152/11 155/9 155/13 157/4 160/17 162/4 162/17 163/14 163/18 185/12 190/11 194/14 194/19 194/21 198/2 204/6 208/1 nations' [1] 152/3 nature [2] 35/25 45/11 near [1] 207/8 necessarily [15] 23/4 32/25 137/1 139/15 148/6 168/3 169/8 173/23 178/10 179/13 180/7 185/22 192/18 196/10 208/8 necessary [1] 109/14 need [39] 15/3 76/3 76/6 99/23 106/12 128/11 133/15 134/22 136/3 136/5 136/21 136/23 139/12 139/22 140/18 140/24 141/3	

N	141/18 148/22 161/6 161/10 167/9 168/18 173/1 177/25 178/2 178/9 178/12 178/14 179/7 183/23 190/10 200/21 201/4	November [3] 20/2 20/3 114/8 November 2021 [2] 20/2 20/3 now [23] 20/19 22/16 37/24 50/9 79/8 80/15 82/24 85/5 88/25 105/15 115/20 118/4 123/14 125/21 128/15 128/19 134/12 149/21 153/23 155/21 168/16 179/3 195/3 nuanced [1] 46/24 nuances [1] 26/17 nub [1] 11/19 number [33] 5/6 7/4 7/25 9/17 12/14 13/25 23/5 30/18 30/19 43/6 49/3 55/25 68/5 69/24 74/20 84/22 92/7 95/17 109/12 109/20 112/16 118/20 128/10 148/5 148/12 148/16 158/15 178/7 185/10 192/24 193/19 203/20 205/5 numbers [7] 15/20 39/10 39/21 59/8 85/3 192/12 200/7 numerous [1] 49/17 nurse [1] 86/19 nurse-based [1] 86/19 nurses [4] 16/5 93/23 94/1 189/18 nursing [5] 113/8 123/23 125/11 125/14 167/11 nurtured [1] 201/7	71/2 71/22 76/10 77/21 79/24 85/2 96/8 96/19 97/13 100/21 103/14 106/23 112/5 112/10 116/7 119/15 120/12 121/16 122/9 123/5 132/21 134/24 139/7 154/8 156/14 158/15 159/4 162/2 163/17 164/5 179/10 190/1 190/3 193/7 194/23 203/17 203/19 occasion [2] 36/19 76/11 occasionally [1] 35/11 occasions [2] 26/14 33/9 occupation [4] 159/8 159/12 160/4 160/12 occupational [2] 130/22 131/7 occupations [1] 160/16 occupied [1] 67/16 occurred [1] 101/1 October [4] 1/13 107/22 108/9 108/15 October 2001 [1] 108/9 October 2020 [1] 108/15 October 2024 [1] 1/13 off [5] 5/10 36/14 41/10 87/23 142/5 offer [16] 12/20 16/12 46/25 59/7 73/7 74/12 112/18 133/16 162/7 163/12 166/22 167/25 168/13 182/4 195/13 208/17 offered [11] 16/22 17/13 17/21 75/23 94/22 95/12 95/17 164/11 165/10 165/14 186/3 offering [5] 43/3 164/23 165/2 178/18 180/6 offers [3] 44/25 54/7 55/9 office [7] 57/8 65/11 67/13 89/25 90/10 90/10 148/17 Officer [23] 4/2 4/8 15/24 65/11 67/1 67/14 68/3 71/12 74/15 100/1 108/7 108/10 108/14 108/18 109/10 109/15 116/6 116/14 120/13 125/23 134/12 135/19 137/3 officers [10] 2/14	2/15 27/21 109/22 111/3 135/19 159/8 176/6 182/23 182/23 Official [1] 41/12 officials [3] 4/9 77/3 167/9 officio [1] 12/9 offload [1] 28/12 often [14] 12/22 25/24 27/10 40/19 47/25 48/1 54/16 57/16 62/7 75/23 96/4 99/18 174/16 177/11 oh [3] 38/23 92/2 204/20 okay [8] 10/16 60/25 61/22 89/1 134/4 167/2 171/5 196/10 old [2] 126/16 188/6 older [3] 56/24 81/20 205/7 olds [10] 13/9 14/17 14/25 15/3 46/8 47/14 47/20 188/16 188/20 188/22 Omicron [2] 17/21 48/15 omission [1] 150/2 omitted [1] 206/13 on [288] once [5] 58/15 58/17 81/2 109/18 138/17 one [68] 3/4 12/3 12/7 16/10 21/8 23/4 34/7 35/8 35/23 38/23 55/3 55/4 55/6 60/24 61/6 66/3 69/18 72/10 76/25 81/17 82/21 92/4 94/12 96/5 98/1 98/18 102/20 103/3 115/16 116/1 119/18 119/24 121/11 123/24 127/2 127/11 128/22 129/11 130/4 130/5 130/7 130/10 132/1 143/8 150/9 154/16 155/17 156/4 157/19 162/2 162/16 163/16 164/25 165/18 174/11 178/13 182/19 185/18 186/6 191/16 194/9 197/23 199/13 201/9 202/20 203/11 203/25 208/12 one health [1] 61/6 ones [4] 101/7 133/9 134/2 137/23 ongoing [2] 119/8 179/3 online [7] 9/5 9/8 55/23 60/8 119/24 120/24 124/17 only [31] 5/14 23/15 50/5 58/16 58/17
	North [1] 92/24 Northern [69] 25/8 25/10 27/3 36/21 77/14 108/8 108/22 109/16 110/4 110/17 110/25 111/8 111/11 111/13 111/16 111/24 112/7 112/16 112/21 112/23 113/2 113/3 113/16 113/21 115/3 115/21 116/21 119/20 120/3 120/9 120/17 122/8 122/22 123/10 124/11 127/10 127/24 128/2 128/13 130/4 130/10 130/10 130/18 130/24 131/16 132/16 132/20 133/4 134/13 135/17 137/4 141/13	November [3] 20/2 20/3 114/8 November 2021 [2] 20/2 20/3 now [23] 20/19 22/16 37/24 50/9 79/8 80/15 82/24 85/5 88/25 105/15 115/20 118/4 123/14 125/21 128/15 128/19 134/12 149/21 153/23 155/21 168/16 179/3 195/3 nuanced [1] 46/24 nuances [1] 26/17 nub [1] 11/19 number [33] 5/6 7/4 7/25 9/17 12/14 13/25 23/5 30/18 30/19 43/6 49/3 55/25 68/5 69/24 74/20 84/22 92/7 95/17 109/12 109/20 112/16 118/20 128/10 148/5 148/12 148/16 158/15 178/7 185/10 192/24 193/19 203/20 205/5 numbers [7] 15/20 39/10 39/21 59/8 85/3 192/12 200/7 numerous [1] 49/17 nurse [1] 86/19 nurse-based [1] 86/19 nurses [4] 16/5 93/23 94/1 189/18 nursing [5] 113/8 123/23 125/11 125/14 167/11 nurtured [1] 201/7	71/2 71/22 76/10 77/21 79/24 85/2 96/8 96/19 97/13 100/21 103/14 106/23 112/5 112/10 116/7 119/15 120/12 121/16 122/9 123/5 132/21 134/24 139/7 154/8 156/14 158/15 159/4 162/2 163/17 164/5 179/10 190/1 190/3 193/7 194/23 203/17 203/19 occasion [2] 36/19 76/11 occasionally [1] 35/11 occasions [2] 26/14 33/9 occupation [4] 159/8 159/12 160/4 160/12 occupational [2] 130/22 131/7 occupations [1] 160/16 occupied [1] 67/16 occurred [1] 101/1 October [4] 1/13 107/22 108/9 108/15 October 2001 [1] 108/9 October 2020 [1] 108/15 October 2024 [1] 1/13 off [5] 5/10 36/14 41/10 87/23 142/5 offer [16] 12/20 16/12 46/25 59/7 73/7 74/12 112/18 133/16 162/7 163/12 166/22 167/25 168/13 182/4 195/13 208/17 offered [11] 16/22 17/13 17/21 75/23 94/22 95/12 95/17 164/11 165/10 165/14 186/3 offering [5] 43/3 164/23 165/2 178/18 180/6 offers [3] 44/25 54/7 55/9 office [7] 57/8 65/11 67/13 89/25 90/10 90/10 148/17 Officer [23] 4/2 4/8 15/24 65/11 67/1 67/14 68/3 71/12 74/15 100/1 108/7 108/10 108/14 108/18 109/10 109/15 116/6 116/14 120/13 125/23 134/12 135/19 137/3 officers [10] 2/14	2/15 27/21 109/22 111/3 135/19 159/8 176/6 182/23 182/23 Official [1] 41/12 officials [3] 4/9 77/3 167/9 officio [1] 12/9 offload [1] 28/12 often [14] 12/22 25/24 27/10 40/19 47/25 48/1 54/16 57/16 62/7 75/23 96/4 99/18 174/16 177/11 oh [3] 38/23 92/2 204/20 okay [8] 10/16 60/25 61/22 89/1 134/4 167/2 171/5 196/10 old [2] 126/16 188/6 older [3] 56/24 81/20 205/7 olds [10] 13/9 14/17 14/25 15/3 46/8 47/14 47/20 188/16 188/20 188/22 Omicron [2] 17/21 48/15 omission [1] 150/2 omitted [1] 206/13 on [288] once [5] 58/15 58/17 81/2 109/18 138/17 one [68] 3/4 12/3 12/7 16/10 21/8 23/4 34/7 35/8 35/23 38/23 55/3 55/4 55/6 60/24 61/6 66/3 69/18 72/10 76/25 81/17 82/21 92/4 94/12 96/5 98/1 98/18 102/20 103/3 115/16 116/1 119/18 119/24 121/11 123/24 127/2 127/11 128/22 129/11 130/4 130/5 130/7 130/10 132/1 143/8 150/9 154/16 155/17 156/4 157/19 162/2 162/16 163/16 164/25 165/18 174/11 178/13 182/19 185/18 186/6 191/16 194/9 197/23 199/13 201/9 202/20 203/11 203/25 208/12 one health [1] 61/6 ones [4] 101/7 133/9 134/2 137/23 ongoing [2] 119/8 179/3 online [7] 9/5 9/8 55/23 60/8 119/24 120/24 124/17 only [31] 5/14 23/15 50/5 58/16 58/17
	not [148] 13/1 13/8 13/22 14/15 16/14 21/4 21/6 21/11 21/22 25/2 25/14 26/1 27/11 28/16 29/4 30/20 32/3 32/24 33/12 39/24 41/24 42/12 43/24 44/8 44/19 46/10 46/14 48/14 53/1 53/13 55/6 56/8 56/14 57/5 58/9 61/19 61/25 67/16 68/5 69/4 69/7 75/17 78/2 80/22 83/21 84/18 84/19 84/19 86/12 86/25 87/15 89/12 90/17 91/15 91/23 93/19 94/20 95/11 96/11 97/17 97/17 98/14 98/21 99/14 99/19 100/21 100/22 100/24 101/13 101/18 102/4 102/11 102/13 104/21 109/2 112/6 112/24 116/4 121/7 122/22 128/12 129/1 129/5 130/9 130/9 130/14 131/20 132/20 133/8 133/19 133/21 134/2 134/21 135/18 136/1 138/16 139/19 139/20 142/5 142/12 146/10 146/22 149/8 149/14 156/10 157/7 159/17 161/8 161/21 163/17 165/9 168/3 168/25 169/4 169/8 172/7 172/20 173/14 175/19 177/2 177/11 177/18 180/7 180/18 181/23 183/20 183/25 185/22 186/3 188/25 193/10 193/14 196/8 196/9 196/10 198/8 198/22 198/23 200/4 201/24 201/25 201/25 205/4 205/5 205/22 207/16 208/4 208/8 notable [1] 152/12 note [8] 60/11 138/19 152/10 179/17 180/17 181/19 185/21 187/23 notice [3] 66/5 77/17 78/21 novel [2] 152/22 178/14	November [3] 20/2 20/3 114/8 November 2021 [2] 20/2 20/3 now [23] 20/19 22/16 37/24 50/9 79/8 80/15 82/24 85/5 88/25 105/15 115/20 118/4 123/14 125/21 128/15 128/19 134/12 149/21 153/23 155/21 168/16 179/3 195/3 nuanced [1] 46/24 nuances [1] 26/17 nub [1] 11/19 number [33] 5/6 7/4 7/25 9/17 12/14 13/25 23/5 30/18 30/19 43/6 49/3 55/25 68/5 69/24 74/20 84/22 92/7 95/17 109/12 109/20 112/16 118/20 128/10 148/5 148/12 148/16 158/15 178/7 185/10 192/24 193/19 203/20 205/5 numbers [7] 15/20 39/10 39/21 59/8 85/3 192/12 200/7 numerous [1] 49/17 nurse [1] 86/19 nurse-based [1] 86/19 nurses [4] 16/5 93/23 94/1 189/18 nursing [5] 113/8 123/23 125/11 125/14 167/11 nurtured [1] 201/7	71/2 71/22 76/10 77/21 79/24 85/2 96/8 96/19 97/13 100/21 103/14 106/23 112/5 112/10 116/7 119/15 120/12 121/16 122/9 123/5 132/21 134/24 139/7 154/8 156/14 158/15 159/4 162/2 163/17 164/5 179/10 190/1 190/3 193/7 194/23 203/17 203/19 occasion [2] 36/19 76/11 occasionally [1] 35/11 occasions [2] 26/14 33/9 occupation [4] 159/8 159/12 160/4 160/12 occupational [2] 130/22 131/7 occupations [1] 160/16 occupied [1] 67/16 occurred [1] 101/1 October [4] 1/13 107/22 108/9 108/15 October 2001 [1] 108/9 October 2020 [1] 108/15 October 2024 [1] 1/13 off [5] 5/10 36/14 41/10 87/23 142/5 offer [16] 12/20 16/12 46/25 59/7 73/7 74/12 112/18 133/16 162/7 163/12 166/22 167/25 168/13 182/4 195/13 208/17 offered [11] 16/22 17/13 17/21 75/23 94/22 95/12 95/17 164/11 165/10 165/14 186/3 offering [5] 43/3 164/23 165/2 178/18 180/6 offers [3] 44/25 54/7 55/9 office [7] 57/8 65/11 67/13 89/25 90/10 90/10 148/17 Officer [23] 4/2 4/8 15/24 65/11 67/1 67/14 68/3 71/12 74/15 100/1 108/7 108/10 108/14 108/18 109/10 109/15 116/6 116/14 120/13 125/23 134/12 135/19 137/3 officers [10] 2/14	2/15 27/21 109/22 111/3 135/19 159/8 176/6 182/23 182/23 Official [1] 41/12 officials [3] 4/9 77/3 167/9 officio [1] 12/9 offload [1] 28/12 often [14] 12/22 25/24 27/10 40/19 47/25 48/1 54/16 57/16 62/7 75/23 96/4 99/18 174/16 177/11 oh [3] 38/23 92/2 204/20 okay [8] 10/16 60/25 61/22 89/1 134/4 167/2 171/5 196/10 old [2] 126/16 188/6 older [3] 56/24 81/20 205/7 olds [10] 13/9 14/17 14/25 15/3 46/8 47/14 47/20 188/16 188/20 188/22 Omicron [2] 17/21 48/15 omission [1] 150/2 omitted [1] 206/13 on [288] once [5] 58/15 58/17 81/2 109/18 138/17 one [68] 3/4 12/3 12/7 16/10 21/8 23/4 34/7 35/8 35/23 38/23 55/3 55/4 55/6 60/24 61/6 66/3 69/18 72/10 76/25 81/17 82/21 92/4 94/12 96/5 98/1 98/18 102/20 103/3 115/16 116/1 119/18 119/24 121/11 123/24 127/2 127/11 128/22 129/11 130/4 130/5 130/7 130/10 132/1 143/8 150/9 154/16 155/17 156/4 157/19 162/2 162/16 163/16 164/25 165/18 174/11 178/13 182/19 185/18 186/6 191/16 194/9 197/23 199/13 201/9 202/20 203/11 203/25 208/12 one health [1] 61/6 ones [4] 101/7 133/9 134/2 137/23 ongoing [2] 119/8 179/3 online [7] 9/5 9/8 55/23 60/8 119/24 120/24 124/17 only [31] 5/14 23/15 50/5 58/16 58/17
	not [148] 13/1 13/8 13/22 14/15 16/14 21/4 21/6 21/11 21/22 25/2 25/14 26/1 27/11 28/16 29/4 30/20 32/3 32/24 33/12 39/24 41/24 42/12 43/24 44/8 44/19 46/10 46/14 48/14 53/1 53/13 55/6 56/8 56/14 57/5 58/9 61/19 61/25 67/16 68/5 69/4 69/7 75/17 78/2 80/22 83/21 84/18 84/19 84/19 86/12 86/25 87/15 89/12 90/17 91/15 91/23 93/19 94/20 95/11 96/11 97/17 97/17 98/14 98/21 99/14 99/19 100/21 100/22 100/24 101/13 101/18 102/4 102/11 102/13 104/21 109/2 112/6 112/24 116/4 121/7 122/22 128/12 129/1 129/5 130/9 130/9 130/14 131/20 132/20 133/8 133/19 133/21 134/2 134/21 135/18 136/1 138/16 139/19 139/20 142/5 142/12 146/10 146/22 149/8 149/14 156/10 157/7 159/17 161/8 161/21 163/17 165/9 168/3 168/25 169/4 169/8 172/7 172/20 173/14 175/19 177/2 177/11 177/18 180/7 180/18 181/23 183/20 183/25 185/22 186/3 188/25 193/10 193/14 196/8 196/9 196/10 198/8 198/22 198/23 200/4 201/24 201/25 201/25 205/4 205/5 205/22 207/16 208/4 208/8 notable [1] 152/12 note [8] 60/11 138/19 152/10 179/17 180/17 181/19 185/21 187/23 notice [3] 66/5 77/17 78/21 novel [2] 152/22 178/14	November [3] 20/2 20/3 114/8 November 2021 [2] 20/2 20/3 now [23] 20/19 22/16 37/24 50/9 79/8 80/15 82/24 85/5 88/25 105/15 115/20 118/4 123/14 125/21 128/15 128/19 134/12 149/21 153/23 155/21 168/16 179/3 195/3 nuanced [1] 46/24 nuances [1] 26/17 nub [1] 11/19 number [33] 5/6 7/4 7/25 9/17 12/14 13/25 23/5 30/18 30/19 43/6 49/3 55/25 68/5 69/24 74/20 84/22 92/7 95/17 109/12 109/20 112/16 118/20 128/10 148/5 148/12 148/16 158/15 178/7 185/10 192/24 193/19 203/20 205/5 numbers [7] 15/20 39/10 39/21 59/8 85/3 192/12 200/7 numerous [1] 49/17 nurse [1] 86/19 nurse-based [1] 86/19 nurses [4] 16/5 93/23 94/1 189/18 nursing [5] 113/8 123/23 125/11 125/14 167/		

O	28/20 29/19 31/11 31/19 33/11 33/24 34/19 35/11 35/24 37/9 37/9 38/3 40/19 41/6 41/15 41/16 42/12 44/2 44/4 44/7 44/24 45/20 47/23 49/24 50/12 53/4 53/25 54/6 54/20 54/20 55/21 55/23 56/4 57/5 60/8 61/17 62/19 67/21 69/6 69/13 70/8 70/19 71/19 72/7 73/11 73/12 78/8 83/21 84/13 85/20 85/21 86/13 87/6 88/10 88/14 89/5 91/1 92/6 93/10 95/6 96/9 97/5 97/5 97/19 98/2 102/20 106/2 106/2 109/2 111/22 112/11 113/2 113/12 115/15 118/20 119/20 121/17 122/15 123/7 124/23 128/9 130/9 130/21 132/13 134/3 136/24 137/2 146/7 146/23 146/23 149/1 149/8 149/14 157/5 158/2 158/4 158/5 158/6 159/8 159/8 161/12 161/19 163/1 165/9 165/13 167/6 167/8 168/6 169/6 169/17 171/17 171/20 172/4 172/6 172/8 173/14 173/17 175/24 177/23 178/17 181/1 181/23 181/23 182/23 183/1 183/19 184/20 184/22 185/15 185/16 186/1 186/1 186/9 189/2 190/6 192/3 192/7 192/16 193/8 193/10 193/15 195/22 196/4 198/16 201/17 202/3 203/11 205/8 205/15 205/22 205/23 oral [1] 121/8 order [25] 16/10 76/5 80/9 82/4 92/7 123/2 124/5 127/14 134/24 138/5 138/13 146/15 152/18 155/9 162/6 166/19 166/21 168/19 171/9 174/19 175/18 184/13 195/22 200/19 208/16 ordinarily [1] 138/16 ordination [2] 71/14 109/25 organisation [3] 133/7 156/15 194/24	organisational [2] 2/11 122/23 organisations [9] 18/19 18/20 18/21 45/8 49/20 53/7 93/21 137/19 207/4 organised [4] 121/4 165/25 172/22 201/3 originally [2] 87/22 123/4 Orthodox [1] 199/1 other [74] 1/24 1/25 4/9 7/5 11/17 12/20 15/16 23/23 24/11 24/19 25/18 26/20 26/23 34/21 47/17 49/14 50/15 53/4 53/15 59/17 62/17 62/19 62/25 67/5 69/11 69/12 69/18 76/9 76/13 77/7 82/8 83/18 86/9 86/13 92/4 92/17 99/21 102/14 103/7 104/5 109/23 111/3 114/9 122/21 125/21 125/21 125/21 129/6 135/2 135/19 136/20 141/1 142/7 143/9 144/24 145/4 155/25 158/1 160/5 174/19 177/10 178/24 179/1 181/23 188/11 188/15 188/22 189/6 189/7 191/4 192/10 195/19 197/6 200/13 other's [2] 24/9 33/19 others [16] 5/14 12/21 24/7 28/12 35/16 37/17 59/7 72/12 96/10 97/16 127/7 171/24 172/14 195/22 202/4 207/23 otherwise [2] 69/13 176/8 ought [3] 72/14 101/18 105/2 our [105] 15/2 15/10 15/10 17/18 22/2 22/2 23/8 23/11 23/12 24/6 24/10 28/10 30/5 33/21 34/23 34/25 35/3 35/5 39/22 43/1 48/16 51/8 54/14 54/15 60/25 68/14 68/24 69/3 69/17 70/16 71/11 71/24 71/25 73/6 73/9 74/15 75/8 75/10 75/13 75/18 76/3 77/3 78/1 80/8 80/22 81/5 82/15 83/2 84/11 84/13 86/17 87/17 87/18 87/19 87/19 87/21 89/24 89/24 91/16	92/12 92/13 92/15 92/21 93/3 93/20 93/23 94/1 94/5 95/4 95/24 95/25 96/7 96/12 96/20 97/9 97/9 97/20 97/25 99/4 99/8 99/9 99/25 100/1 100/8 100/9 100/10 103/1 104/2 104/14 116/5 117/12 120/2 124/21 127/11 128/22 133/18 135/24 149/18 149/24 170/6 171/15 186/13 189/16 201/20 204/2 ourselves [1] 99/14 out [67] 7/4 7/8 7/11 8/24 9/6 19/2 23/25 33/23 35/18 35/20 36/4 39/8 41/21 42/22 44/6 45/17 46/11 48/6 49/17 50/2 51/3 51/13 52/16 53/14 55/25 58/8 58/25 59/1 59/10 62/20 66/15 70/6 78/16 79/8 79/9 79/10 79/14 80/3 81/4 87/23 97/18 100/8 103/24 119/4 121/3 121/22 123/23 124/1 124/3 125/14 125/24 127/18 131/6 138/4 138/5 138/9 138/18 139/17 141/2 141/7 148/5 148/8 154/20 158/10 180/8 191/2 200/20 outbreaks [1] 171/18 outcome [3] 50/20 53/19 97/7 outcomes [3] 98/9 196/15 196/19 outlier [3] 167/16 181/24 181/25 outline [1] 169/16 outlined [1] 88/19 outreach [15] 43/20 44/9 45/6 62/14 62/16 93/16 129/23 131/20 152/18 155/13 155/16 180/22 192/16 201/8 205/23 outset [2] 138/7 139/3 outside [7] 30/22 46/4 87/10 134/16 167/19 176/11 176/12 outsider [1] 136/18 outweighed [1] 105/17 outwith [1] 60/13 over [43] 7/18 9/10 10/18 13/5 13/8 14/17 15/3 20/16 39/14 41/23 44/17 44/23	44/23 70/8 75/9 75/19 82/10 86/7 87/3 87/5 112/20 115/13 123/19 129/9 141/13 143/23 184/4 186/1 186/1 187/15 187/15 188/2 188/4 188/5 188/5 188/10 188/16 188/20 188/22 190/23 193/2 200/7 206/25 over-12s [1] 186/1 over-18s [1] 186/1 over-80 [2] 10/18 188/10 over-complicated [1] 70/8 over-fifties [1] 188/4 over-seventies [1] 44/23 over-sixties [1] 44/23 overall [6] 12/1 24/1 138/23 150/16 153/9 207/15 overarching [5] 38/3 39/7 78/12 150/22 151/18 overlap [1] 157/11 overlaps [1] 195/9 overlooked [1] 206/14 overly [1] 116/4 overnight [1] 17/24 overseen [2] 11/23 49/15 oversight [12] 12/2 110/3 110/22 112/12 115/23 116/1 116/5 116/13 116/25 117/8 148/15 178/3 overspeaking [4] 151/14 156/24 190/22 194/25 overview [5] 79/8 111/10 121/12 122/1 145/15 own [20] 28/10 35/15 61/2 61/3 68/24 69/3 74/8 74/9 78/2 78/6 87/23 99/20 100/22 101/20 118/16 119/21 145/7 145/9 157/15 180/7 Owner [3] 66/13 67/2 108/21 Owners [1] 64/13
			P	
			pace [10] 22/13 45/2 48/19 73/4 128/14 154/1 178/19 184/17 204/11 206/12 pack [2] 14/12 15/25 package [2] 40/21	

P	165/18 184/11 200/24 pages 11 [1] 149/14 pages 26 [1] 165/18 pages 43 [1] 184/11 pages 89 [1] 200/24 pages 9 [1] 146/6 paid [3] 99/18 148/20 159/7 pains [1] 97/25 pairing [1] 140/4 pandemic [37] 2/20 8/3 22/8 63/4 65/15 67/17 73/16 76/2 77/1 87/14 88/5 127/25 136/10 141/17 151/2 151/16 154/2 155/10 162/18 162/19 164/20 166/23 168/10 169/19 170/4 170/11 172/3 179/6 184/10 193/3 194/1 195/24 201/25 203/10 204/8 206/7 206/16 pandemics [3] 144/1 171/18 172/15 paper [3] 51/3 51/3 98/19 paperwork [2] 10/3 12/6 paragraph [31] 7/9 36/22 38/25 41/11 41/24 79/16 85/22 105/8 146/13 147/4 148/4 148/8 150/25 152/8 168/24 169/5 169/13 170/17 170/25 171/1 171/2 172/16 172/18 174/22 176/9 178/16 180/25 187/1 203/7 205/3 205/10 paragraph 10 [1] 41/24 paragraph 103 [1] 174/22 paragraph 107 [1] 176/9 paragraph 11 [1] 146/13 paragraph 116 [1] 178/16 paragraph 12 [1] 148/4 paragraph 123 [1] 180/25 paragraph 13 [1] 147/4 paragraph 15 [1] 150/25 paragraph 179 [1] 187/1 paragraph 18 [1] 152/8 paragraph 2 [1] 79/16	paragraph 21 [1] 148/8 paragraph 237 [1] 105/8 paragraph 250 [1] 205/10 paragraph 370 [1] 203/7 Paragraph 6 [1] 41/11 paragraph 95 [2] 168/24 169/5 paragraph 98 [1] 169/13 paragraph 99 [1] 205/3 paragraph 99b [1] 170/17 paragraph 99c [1] 171/1 paragraphs [1] 138/1 paragraphs 197 [1] 138/1 parallel [1] 18/23 parameters [2] 72/6 72/13 parcel [1] 33/15 parent [1] 168/5 parental [1] 166/19 parents [4] 46/21 48/3 166/25 168/11 parity [1] 73/1 Parker [1] 145/2 parks [1] 49/22 Parliament [1] 37/15 part [34] 3/23 8/15 10/10 12/3 12/22 15/16 16/8 21/10 24/24 27/16 33/15 40/20 41/9 48/22 49/24 55/21 62/6 70/13 82/15 87/22 95/2 106/24 108/15 111/19 115/7 140/22 146/10 146/18 149/9 156/18 171/22 171/25 172/1 175/7 Participants [1] 203/18 participation [1] 73/12 particular [59] 2/3 14/8 15/15 21/8 21/12 21/17 28/7 28/23 29/19 36/11 44/5 45/17 54/3 55/13 59/19 74/4 76/10 79/19 82/14 83/9 83/11 83/22 88/10 92/9 93/24 96/2 100/7 100/12 102/19 106/1 106/2 118/8 118/17 119/18 125/10 127/2 131/5 134/6 134/16	135/23 143/1 144/15 153/13 153/15 154/13 155/14 156/3 156/6 159/2 159/7 160/6 160/15 179/24 183/8 188/20 192/22 194/15 207/13 208/7 particularised [1] 44/6 particularly [37] 10/14 33/20 37/18 37/19 43/9 43/19 45/16 51/23 56/24 60/14 66/8 74/4 81/6 91/10 93/9 99/12 118/19 124/22 125/2 129/4 132/4 135/4 135/20 137/7 138/15 139/24 140/12 147/17 148/1 152/11 153/21 155/24 159/23 180/20 184/3 185/6 199/1 particulars [1] 23/3 partners [2] 68/8 152/23 partnership [4] 144/21 177/24 198/24 199/3 parts [14] 9/17 9/18 26/21 34/22 49/14 114/20 114/21 122/21 123/24 130/12 146/14 147/1 180/18 180/18 party [2] 24/21 37/3 passage [1] 18/11 past [2] 105/13 177/22 patchwork [1] 156/9 patchy [1] 42/2 pathways [1] 152/22 patient [7] 9/14 19/5 19/16 19/22 70/14 104/3 104/3 patients [9] 53/10 88/13 89/25 94/5 126/10 126/11 194/5 194/7 197/8 Patricia [6] 110/8 110/12 111/1 116/7 116/23 120/13 pausing [2] 193/1 201/4 Payment [1] 101/21 Payne [1] 74/16 PCNs [2] 173/6 173/17 peacetime [3] 87/15 102/7 106/12 peculiar [1] 130/18 peer [1] 77/5 Peninsula [1] 92/24 people [130] 18/7 21/14 23/6 29/4 29/25 29/25 37/20 39/10	42/5 42/8 43/17 44/19 45/12 49/23 54/7 54/23 55/21 55/22 56/14 57/13 59/16 60/3 60/7 61/14 61/25 62/4 62/17 62/20 62/21 63/2 73/2 86/2 86/6 88/13 88/15 89/5 89/12 89/19 90/15 91/1 91/7 91/11 91/18 91/19 91/19 93/5 94/4 96/4 96/13 96/23 97/4 99/1 101/8 102/5 103/22 104/7 106/14 110/10 116/7 120/14 121/10 123/19 123/19 124/16 124/19 124/19 125/21 126/12 126/13 126/21 127/5 127/15 127/21 129/25 130/22 132/12 134/7 134/8 134/25 135/3 135/11 135/14 135/20 136/3 136/7 136/19 136/23 137/2 139/3 139/18 139/19 140/10 141/2 142/3 142/7 153/23 161/23 162/6 162/24 165/8 165/24 166/5 171/20 175/13 175/14 175/15 176/7 176/23 178/8 181/4 185/17 186/18 187/10 187/14 187/19 188/10 188/10 191/13 196/14 197/11 198/23 205/7 205/8 205/10 205/18 206/3 207/15 207/16 207/18 208/4 people's [3] 44/18 195/25 207/4 per [2] 75/18 174/21 perceived [1] 109/3 percentage [4] 24/1 24/1 186/10 190/9 perfectly [2] 16/23 44/14 performance [4] 72/6 72/9 72/10 83/13 performed [1] 63/2 perhaps [46] 10/13 12/15 17/6 18/12 23/4 27/15 27/18 28/19 30/25 46/10 49/13 50/4 56/2 70/19 71/5 72/10 73/21 74/4 79/5 80/14 86/11 90/17 95/13 96/23 99/2 101/18 109/4 118/23 118/23 119/9 122/17 125/7 139/11 139/22 139/22 140/17 140/20 143/8 149/1 152/13 169/15 172/25 183/5
----------	---	---	---	--

P	49/23 53/9	56/13 56/15	pop-up [3] 89/8 122/13 201/5	124/8 169/23 173/17 173/18
perhaps... [3] 183/25 184/6 191/1	pick [3] 45/8 140/24 146/7	play [2] 145/25 174/2	population [32] 2/24 3/1 5/3 20/23 23/8	practitioners [2] 92/17 123/17
period [6] 62/8 115/13 118/14 127/17 129/9 198/18	picking [2] 170/16 184/11	played [6] 9/1 48/12 106/24 112/22 127/1 178/25	23/16 46/6 66/7 74/23 75/3 75/6 75/10 75/11	pragmatic [7] 15/2 16/7 24/8 114/5
permanent [1] 1/19	picture [6] 130/3 155/9 167/17 194/13	playing [1] 42/23	76/4 76/7 82/13 83/5 113/19 114/22 137/6	157/20 159/12 180/5
permanently [1] 104/12	208/6 208/8	please [50] 1/8 1/14 7/3 7/7 12/25 17/10	138/18 166/15 183/13 185/22 185/22 185/24	pre [3] 104/23 150/13 174/17
permissive [1] 97/25	piece [4] 19/21 36/6 41/19 156/9	31/7 32/19 36/18 38/1 38/21 40/24 48/6 51/1	186/13 191/10 191/14 200/2 200/3 202/23	pre-booking [1] 174/17
permitted [2] 94/13 106/9	pieces [1] 102/16	51/12 52/1 59/3 63/16 63/21 65/23 75/1 79/7	population-level [2] 5/3 23/8	pre-delivery [1] 150/13
person [3] 94/2 96/6 162/14	pin [1] 18/22	79/9 79/23 81/13 82/2 84/6 85/10 85/18	populations [4] 76/9 155/15 159/4 192/23	pre-existing [1] 104/23
personal [2] 100/23 101/20	pivot [2] 17/1 48/14	98/11 98/21 100/14 103/21 107/12 107/17	portal [1] 96/12	precursor [1] 87/11
personally [1] 135/13	pivoted [7] 18/22 54/15 202/14 202/19	108/23 117/20 122/25 137/15 142/20 146/5	portion [1] 23/18	predicated [2] 8/5 34/25
persons [6] 39/8 55/10 165/14 165/20 166/7 166/11	202/24 203/9 208/2	146/7 161/5 174/22 182/6 185/3 185/14	position [25] 1/18 4/4 13/5 13/16 25/6 29/9	preferable [1] 23/9
perspective [4] 86/12 102/5 150/19 163/22	pivoting [1] 192/8	186/25 191/21 209/7	31/2 31/8 31/24 32/11 33/13 36/24 37/5 51/4	preferred [1] 94/4
persuade [2] 135/14 135/20	pizza [3] 14/7 16/1 173/3	pleased [1] 115/18 107/9 160/23 160/25 209/8	51/6 66/14 85/19 108/7 128/19 128/20	pregnant [1] 158/17
Pfizer [16] 14/8 15/15 16/3 79/25 80/1 80/18 92/19 123/5 124/2 124/9 159/24 174/9 178/24 179/8 179/11 181/18	place [41] 7/17 7/25 25/12 37/9 39/3 43/2	pm [6] 34/15 107/7 107/9 160/23 160/25 209/8	150/11 161/6 161/7 197/21 200/16	preliminary [2] 63/24 107/21
123/5 124/2	50/17 54/25 55/3 73/18 92/10 94/7	point [43] 6/3 20/15 46/17 47/17 56/8 61/4 61/11 66/15 81/23	positions [2] 29/15 65/2	premise [1] 27/7
Pfizer-BioNTech [2] 123/5 124/2	103/1 103/24 112/6 119/1 121/19 122/2 129/2 129/12 129/16	83/25 92/4 94/12 108/17 109/5 114/24	possibility [1] 138/22	preparation [1] 84/15
pharmaceutical [5] 2/14 15/24 71/11 84/7 84/10	129/24 136/25 140/7 140/14 162/18 162/21	123/12 125/22 127/8 128/11 137/10 147/4	possible [21] 11/10 11/11 29/11 58/3 58/4	preparations [1] 3/24
pharmacies [19] 5/14 10/8 39/5 49/1 82/1 117/1 173/9 173/12 173/14 173/16 173/25 174/6 174/10 174/12 174/18 178/6 178/22 179/4 192/16	168/6 169/14 169/15 170/1 174/15 181/23 183/10 184/19 192/17 192/19 193/20 198/25 199/5 206/17	149/3 149/18 149/24 152/15 154/8 156/5 168/2 169/20 170/10 175/14 184/12 187/1 188/7 188/16 191/2	199/23 200/10 200/12 200/12	prepare [2] 66/2 206/6
pharmacist [2] 6/18 16/2	placed [1] 163/23	193/11 195/6 197/11 201/23 203/6 204/19 206/18	possibly [5] 136/22 137/7 177/2 184/24 205/5	prepared [3] 40/25 138/22 150/5
pharmacists [3] 11/1 12/20 84/14	placement [1] 85/13	points [6] 130/5 151/3 151/18 165/23 170/16 185/8	post [6] 25/7 25/14 27/19 108/10 139/8 167/3	preparedness [2] 170/19 179/6
pharmacy [5] 84/9 116/9 121/25 122/11 173/11	places [2] 171/21 205/13	police [1] 159/8	post-devolution [1] 25/7	preparing [2] 208/22 209/1
phase [2] 13/9 162/1	plainly [2] 2/2 157/13	policies [9] 1/23 4/13 134/11 134/14 134/20	post-marketing [1] 139/8	prescriptive [1] 40/16
phase I [1] 162/1	plan [29] 17/16 17/17 38/2 38/3 38/22 38/24	136/6 136/24 136/24 176/21	post-vaccination [1] 167/3	presence [1] 183/19
phases [2] 71/5 139/7	39/7 65/25 68/6 68/10 72/22 77/9 77/15 78/8 81/15 88/4 88/20 88/24 94/9 117/15	policy [22] 1/25 2/18 3/18 4/15 12/24 15/17 27/12 29/10 41/5 51/4	posters [1] 9/14	present [2] 17/21 105/13
phenomenal [1] 19/8	119/20 119/22 120/18 121/13 121/14 122/1 126/18 151/2 165/21	51/6 53/3 65/5 89/23 103/3 109/25 111/15 143/14 143/15 148/14 165/9 181/20	potential [1] 41/17	presented [1] 78/14
phone [2] 56/17 60/8	planned [2] 110/21 115/22	political [2] 37/4 151/24	practical [11] 8/9 26/11 36/15 37/25	press [2] 35/13 37/15
phoned [1] 42/18	planning [22] 18/13 18/14 48/9 51/15 66/4	politicians [1] 28/18	38/17 53/12 58/15 117/6 132/14 174/9 180/15	pressing [1] 78/15
phones [1] 53/5	66/12 67/11 67/21 70/15 105/4 110/5 115/15 120/11 121/6 149/12 149/16 150/13	politics [2] 35/25 36/3	practices [11] 14/3 14/5 81/23 121/24 122/24 123/9 124/6	pressure [1] 5/10
phoning [2] 55/22 59/2	150/23 168/17 168/22 187/21 206/10	pooling [1] 103/16		pressures [1] 67/16
physical [4] 88/10 163/1 197/13 205/8	plans [18] 15/2 15/10 24/6 34/25 37/16 38/5	poorer [1] 98/8		presumably [15] 3/3 3/7 5/1 16/19 19/10 20/21 23/20 28/14 33/9 38/7 42/4 78/20 144/2 180/12 197/4
physically [3] 22/20	38/7 43/15 50/24 52/3 52/15 78/10 81/24 118/20 119/8 120/2 170/19 178/10	pop [3] 89/8 122/13 201/5		Pretty [1] 11/21

<p>P</p> <p>primary... [25] 14/3 30/1 64/14 70/2 71/6 81/16 81/20 92/17 122/11 126/8 148/24 149/4 149/25 150/17 169/23 169/25 171/1 172/16 172/19 173/2 180/3 180/4 183/4 192/15 205/22</p> <p>Prime [2] 33/6 34/16</p> <p>Prime Minister [2] 33/6 34/16</p> <p>principle [2] 5/24 138/11</p> <p>principles [1] 114/6</p> <p>prior [4] 22/18 50/7 66/5 86/19</p> <p>prioritisation [23] 28/7 43/24 59/10 66/10 68/19 68/24 68/25 74/8 95/25 135/7 151/19 157/1 157/1 157/6 159/11 161/3 161/19 162/9 162/25 163/9 184/14 205/6 207/23</p> <p>prioritise [3] 29/20 57/8 114/23</p> <p>prioritised [5] 135/8 159/15 161/25 164/11 164/22</p> <p>prioritising [1] 10/17</p> <p>priority [34] 10/20 16/9 16/21 16/21 17/13 28/8 34/18 39/9 55/14 61/7 61/8 73/7 94/14 95/10 117/13 124/13 126/12 126/14 126/23 130/14 135/9 158/6 159/6 160/2 162/14 164/2 164/8 165/5 175/7 178/16 178/20 187/7 188/12 203/13</p> <p>priority groups 1 [1] 73/7</p> <p>prison [1] 191/14</p> <p>private [1] 195/25</p> <p>probably [13] 23/13 39/19 54/9 60/11 102/20 112/8 119/12 128/3 149/21 167/23 168/11 178/25 203/11</p> <p>problem [12] 23/14 31/9 36/11 41/15 41/24 50/12 55/8 102/9 166/17 194/20 196/4 198/5</p> <p>problems [7] 163/11 174/8 193/5 193/10 193/21 198/4 206/7</p> <p>procedures [6] 104/2</p>	<p>110/24 138/5 140/13 145/24 177/15</p> <p>proceed [1] 45/2</p> <p>proceeded [1] 118/13</p> <p>process [33] 7/17 8/8 22/21 28/3 31/16 33/15 40/15 135/7 139/6 141/5 146/14 146/19 146/22 147/8 148/6 148/12 149/9 150/22 153/11 158/24 165/16 166/3 166/6 167/4 168/10 169/14 175/2 175/7 177/19 179/13 180/2 181/1 182/13</p> <p>processes [10] 145/11 145/24 146/10 151/5 153/8 155/2 166/18 176/16 177/16 201/9</p> <p>processors [1] 131/8</p> <p>procured [1] 22/25</p> <p>procurement [8] 24/17 146/23 147/9 148/15 149/16 151/4 151/19 152/5</p> <p>produce [4] 38/3 77/25 186/10 192/1</p> <p>produced [5] 28/15 33/10 71/1 118/9 194/6</p> <p>products [1] 40/10</p> <p>professional [5] 64/7 64/21 65/16 108/3 135/19</p> <p>professionals [12] 104/9 106/6 140/15 171/11 171/16 171/21 171/23 172/13 176/23 177/3 180/10 189/17</p> <p>professions [1] 87/2</p> <p>professor [11] 63/15 63/17 106/19 133/13 143/13 144/9 145/2 145/2 145/5 174/4 210/8</p> <p>PROFESSOR DR [2] 63/17 210/8</p> <p>Professor Dr Gillian [1] 63/15</p> <p>Professor Helen [1] 145/5</p> <p>Professor Richardson [1] 106/19</p> <p>Professor Sandra [1] 145/2</p> <p>Professor Sir Michael [1] 133/13</p> <p>profound [4] 97/5 158/3 163/5 165/19</p> <p>profoundly [1] 98/2</p>	<p>programme [143] 4/6 4/19 4/20 5/2 5/7 5/10 5/17 6/2 6/5 6/5 6/10 6/12 6/13 6/14 6/16 6/24 7/2 7/6 7/22 8/1 8/2 8/5 8/7 9/2 9/4 10/7 10/11 11/8 13/23 14/22 15/1 16/24 17/1 17/19 17/22 18/10 18/15 19/24 19/25 20/9 20/11 20/20 20/23 21/7 24/25 28/4 29/2 29/13 30/4 32/25 33/7 33/23 35/17 35/22 37/13 37/17 38/1 43/15 44/7 44/11 46/2 46/19 47/9 48/14 49/25 51/2 51/5 51/7 53/16 56/24 58/1 64/16 65/22 66/14 67/7 67/21 69/17 70/16 70/21 71/4 71/7 73/4 75/5 79/15 84/2 85/7 86/17 86/18 90/3 90/21 109/9 110/3 110/11 112/1 112/3 112/5 112/14 113/5 113/9 113/10 115/22 116/15 117/10 117/12 118/10 120/3 124/22 126/5 127/10 128/23 131/22 132/17 133/14 134/13 137/5 138/9 139/14 140/12 147/3 150/7 150/25 153/7 153/13 153/16 166/24 167/8 167/10 167/13 175/25 178/3 179/3 179/5 179/21 193/17 195/23 202/14 202/18 202/24 203/8 204/4 207/12 207/20 208/9</p> <p>programme's [1] 29/7</p> <p>programmes [25] 50/15 59/22 72/16 104/24 111/23 111/24 114/9 115/2 144/22 150/2 150/18 152/11 152/14 152/21 153/10 153/22 154/8 156/13 167/21 176/20 179/23 189/21 189/21 197/5 198/10</p> <p>progress [2] 68/9 177/12</p> <p>progressing [1] 64/23</p> <p>project [1] 129/18</p> <p>projects [1] 132/10</p> <p>prominent [1] 184/6</p> <p>promise [1] 208/23</p> <p>promote [2] 96/12 199/6</p>	<p>promoting [2] 95/4 200/9</p> <p>promotion [1] 1/17</p> <p>prompt [1] 57/11</p> <p>pronunciation [1] 131/15</p> <p>proper [7] 53/8 53/8 79/12 92/10 109/25 110/3 184/22</p> <p>properly [8] 33/12 43/10 52/10 55/9 67/21 135/25 140/25 149/11</p> <p>proportion [4] 75/3 186/18 188/19 189/8</p> <p>proportionate [2] 89/2 113/18</p> <p>prose [1] 145/8</p> <p>prospect [1] 93/6</p> <p>prospective [4] 3/25 27/14 197/8 199/12</p> <p>protect [5] 66/21 100/11 134/25 134/25 136/22</p> <p>protected [6] 11/11 58/4 83/18 135/16 169/7 208/14</p> <p>protecting [1] 165/4</p> <p>protection [12] 1/15 1/21 2/1 2/3 3/3 6/19 41/7 108/19 111/18 135/10 135/10 144/15</p> <p>protective [1] 190/22</p> <p>protocol [5] 40/13 40/20 49/14 103/23 171/9</p> <p>protocols [2] 19/3 104/1</p> <p>proud [1] 32/10</p> <p>prove [2] 39/14 150/11</p> <p>proved [2] 10/13 171/11</p> <p>provide [20] 4/12 18/23 30/21 32/7 48/7 51/22 74/5 108/16 112/25 112/25 134/3 165/12 174/19 174/20 183/11 185/10 185/17 190/8 190/15 191/12</p> <p>provided [9] 9/4 9/14 31/20 37/14 74/20 113/3 120/19 183/7 185/15</p> <p>provider [1] 166/17</p> <p>providers [5] 53/6 152/20 153/23 166/21 184/21</p> <p>providing [7] 21/12 89/4 149/22 173/19 174/3 184/17 198/15</p> <p>proving [1] 36/5</p> <p>provision [14] 1/12 11/15 143/1 148/23</p>	<p>149/4 158/19 169/25 170/18 171/4 174/16 175/16 175/20 180/3 180/11</p> <p>provisions [2] 89/20 90/24</p> <p>public [111] 2/2 2/5 2/6 2/10 2/13 3/15 6/18 9/13 9/18 12/9 12/10 22/21 25/7 25/10 25/21 28/18 29/1 29/13 30/7 30/24 33/22 33/22 34/11 35/13 35/19 35/21 36/10 36/13 37/7 37/8 37/15 37/17 37/21 59/11 60/21 64/13 64/14 64/23 64/24 65/3 65/6 65/13 67/8 67/17 67/24 73/15 78/1 78/11 80/23 85/7 85/20 86/11 90/12 93/10 94/7 97/18 102/11 102/19 105/22 108/5 108/10 108/12 111/11 111/14 111/15 111/17 111/21 112/6 112/13 115/12 116/10 119/5 119/20 120/2 120/8 120/21 120/25 121/3 121/5 129/21 130/15 137/25 138/10 138/21 139/13 139/25 140/3 140/15 140/19 143/13 143/24 144/9 146/19 147/2 148/22 149/15 149/20 150/6 152/4 157/25 176/5 180/23 182/11 182/14 184/4 188/22 190/8 198/19 200/14 202/15 207/8</p> <p>publication [1] 83/6</p> <p>publicise [1] 96/16</p> <p>publish [4] 31/4 32/8 32/9 78/6</p> <p>published [13] 17/17 37/16 38/6 77/19 79/1 82/9 85/16 96/15 119/4 119/24 190/9 200/24 201/10</p> <p>pull [1] 120/23</p> <p>purpose [4] 10/20 20/10 65/24 65/25</p> <p>purposes [4] 113/5 116/21 143/3 161/21</p> <p>pursued [2] 165/21 166/12</p> <p>push [1] 57/10</p> <p>put [35] 18/18 29/3 33/23 36/12 36/24 37/7 37/8 37/9 37/10 37/11 42/16 43/2 49/16 50/17 52/12</p>
--	---	---	--	--

P	113/22 114/10 114/12 118/9 122/5 123/15 124/16 124/25 128/24 129/18 132/6 132/16 139/6 139/13 140/22 141/25 147/16 148/6 152/20 155/11 158/23 162/1 164/19 165/8 166/24 169/24 169/25 170/1 172/9 172/11 178/19 180/21 190/5 196/25 204/23	125/6 165/4 realised [1] 85/3 reality [4] 25/6 52/12 156/19 199/11 really [72] 24/3 24/8 28/25 29/8 37/14 44/8 54/13 56/18 64/11 70/9 80/2 83/1 87/3 88/21 90/19 95/3 95/6 100/4 102/22 111/6 112/22 112/22 116/3 116/16 116/17 117/25 121/1 121/2 121/5 121/10 124/12 126/9 127/3 132/14 132/14 134/9 134/17 135/23 136/2 138/25 138/25 139/1 139/11 142/2 145/12 155/11 157/7 159/25 162/8 166/9 167/7 171/11 174/2 175/16 175/18 176/1 176/18 177/21 178/18 178/21 181/7 188/13 189/15 192/14 192/14 192/21 195/3 196/1 196/17 200/4 202/5 208/25 realtime [5] 19/13 21/24 192/11 202/17 207/9 reason [3] 15/22 19/18 135/12 reasonable [2] 166/24 167/3 reasonably [2] 101/15 184/15 reasoning [1] 136/16 reasons [3] 13/25 72/10 191/16 reassurance [1] 89/12 reassuring [1] 150/20 rebut [1] 37/23 recall [17] 16/23 23/11 24/10 28/23 30/18 32/4 34/13 34/16 41/3 57/2 57/12 58/21 61/20 83/3 119/23 120/6 201/11 receipt [4] 42/10 42/12 96/9 161/21 receive [6] 38/9 39/9 58/11 58/23 80/7 163/12 received [12] 11/12 58/5 77/19 104/3 150/5 161/11 185/18 187/2 187/9 187/16 188/2 189/3 receiving [8] 19/6 44/19 57/14 87/12 102/6 103/22 162/14	186/11 recent [1] 36/23 recently [2] 64/3 107/25 recipient [1] 19/22 recipients [2] 17/13 195/21 recognise [6] 13/20 13/21 13/24 51/7 196/14 197/10 recognised [3] 75/12 195/15 198/17 recognising [4] 15/2 81/18 181/14 197/19 recognition [1] 4/5 recommendation [3] 13/23 156/21 203/14 recommendations [12] 156/1 156/19 170/12 203/1 203/11 203/21 203/22 204/1 204/10 204/12 204/14 208/13 recommended [2] 45/14 71/8 reconstituting [1] 84/18 record [9] 18/18 19/10 19/20 20/4 128/5 128/7 168/25 169/1 169/4 recorded [6] 19/23 19/24 161/8 193/11 194/5 208/5 recording [6] 22/8 22/17 56/7 58/22 82/20 128/18 records [5] 19/11 19/17 161/9 169/3 169/8 recover [1] 142/7 recovers [1] 101/4 reduce [2] 50/19 153/16 reduced [3] 18/2 44/2 205/24 reducing [3] 18/2 158/9 196/5 reductions [1] 189/10 reel [1] 68/5 refer [19] 9/1 25/3 56/19 67/19 116/22 148/4 149/14 152/8 161/13 168/25 169/9 170/21 174/24 177/25 180/23 200/23 200/25 201/5 207/5 reference [10] 9/3 13/12 30/24 34/9 39/24 82/17 158/1 169/3 175/23 182/20 references [3] 7/4 13/13 33/5	referral [1] 103/8 referred [8] 9/14 40/23 54/24 62/1 68/18 95/16 204/5 207/12 referring [4] 8/1 14/10 20/10 30/10 refers [2] 35/24 71/16 refine [1] 132/5 refined [1] 132/19 refinement [1] 128/24 reflect [5] 21/13 23/4 25/14 27/19 54/9 reflected [2] 12/24 33/12 reflecting [2] 20/25 116/2 reflection [1] 147/8 refreshing [1] 102/20 regard [3] 150/11 159/7 181/24 regarded [2] 40/2 146/11 region [3] 145/17 154/12 183/8 regional [15] 7/13 134/15 174/25 175/3 175/17 176/1 176/4 176/5 176/14 176/22 177/8 178/8 184/3 184/23 198/2 regional-based [1] 178/8 regions [1] 182/20 register [7] 42/1 54/25 161/9 161/16 163/16 163/20 164/10 registered [2] 92/6 96/9 registers [1] 97/19 registrar [1] 85/13 regular [3] 2/10 76/14 115/7 regularly [2] 100/1 183/16 regulations [1] 80/25 rehabilitate [1] 101/2 rein [1] 24/10 reinforce [1] 127/8 reiterate [1] 188/7 relate [1] 2/1 related [7] 4/14 25/11 108/17 143/17 146/24 168/22 198/2 relates [1] 36/7 relating [3] 36/4 111/14 194/6 relation [17] 7/20 7/21 33/2 36/11 40/14 44/21 44/23 46/8 54/23 168/24 174/5 174/5 193/10 193/21
put... [20] 55/3 73/18 78/1 102/16 105/15 118/25 119/1 128/14 128/16 129/1 129/16 129/24 136/25 139/17 140/13 165/15 169/14 169/15 181/8 208/24 putting [4] 20/24 37/5 37/23 199/15 puzzling [1] 131/13	quote [1] 105/9 quoted [1] 30/19			
Q	qualified [1] 50/7 qualitative [1] 154/24 quality [1] 155/5 quarterly [1] 200/25 querying [1] 95/5 question [28] 9/21 20/24 27/15 59/20 60/20 61/23 105/18 133/17 133/23 134/4 136/2 136/12 136/13 138/19 140/3 162/20 164/20 174/4 182/3 189/24 190/3 190/5 201/16 201/18 203/25 204/3 207/17 207/24 questions [40] 1/7 1/15 42/22 56/18 57/19 57/20 57/21 57/22 62/23 63/18 104/16 104/19 104/20 107/14 132/23 133/1 133/4 137/16 137/24 141/11 142/19 164/17 167/2 194/24 204/22 204/25 205/14 207/2 207/3 208/21 210/4 210/6 210/10 210/11 210/14 210/15 210/16 210/20 210/22 210/23 queues [1] 84/21 quick [4] 76/20 115/6 204/23 204/24 quicker [5] 15/15 23/6 125/8 199/4 199/6 quickly [14] 14/24 15/21 119/1 119/5 123/15 123/24 124/3 124/16 124/18 125/7 142/8 170/9 188/11 199/18 quiet [1] 93/25 quieter [1] 205/23 quirk [1] 25/3 quite [55] 8/20 13/1 20/6 20/8 30/21 37/20 43/13 47/11 52/7 54/9 54/15 54/18 56/5 66/6 66/19 91/17 94/20 99/18 111/6 111/7	R radio [1] 51/24 raft [1] 49/20 Rahma [1] 145/5 raise [3] 14/19 149/18 167/24 raised [4] 164/18 164/25 170/10 204/19 ramp [1] 14/23 ran [2] 23/24 56/10 range [8] 1/23 1/25 17/23 19/1 52/24 69/20 115/14 183/6 ranges [1] 83/15 rapid [2] 103/17 152/8 rapidly [6] 99/24 138/11 166/23 169/24 172/15 189/3 rare [4] 102/15 138/15 138/19 140/25 rarity [1] 140/5 rate [3] 100/10 103/14 189/10 rates [7] 21/19 22/4 99/3 187/5 187/13 192/2 200/11 rather [11] 23/5 25/11 46/7 48/5 49/10 60/17 62/21 73/11 112/12 186/1 186/7 reach [12] 31/23 32/6 32/11 81/9 82/4 88/23 166/10 173/14 199/19 199/24 200/1 200/4 reached [4] 31/9 187/20 188/3 199/25 reaching [5] 52/16 81/19 155/1 180/8 188/21 reaction [2] 69/8 140/8 read [3] 64/3 89/5 107/25 readily [2] 153/12 203/9 readiness [1] 202/14 reading [1] 203/19 real [4] 24/2 57/14		

R	25/15 102/10 102/10 102/14 102/15 117/7 140/16 200/25 represent [4] 121/20 136/19 137/19 137/21 representation [4] 70/10 182/11 183/15 189/20 representative [3] 67/9 109/16 198/21 representatives [8] 27/2 37/2 70/15 74/7 88/22 93/22 176/24 182/9 represented [1] 82/12 representing [1] 90/11 repromoting [1] 102/20 request [2] 36/25 77/13 requested [1] 71/7 requesting [1] 99/17 require [1] 128/24 required [5] 16/25 28/19 75/8 113/11 146/15 requirement [3] 92/6 95/11 171/22 requirements [3] 79/25 156/16 173/21 requires [2] 121/4 154/23 requiring [3] 50/23 52/15 171/24 research [9] 64/24 65/5 74/3 85/19 104/23 143/16 144/14 144/16 175/23 resented [1] 99/1 reserve [1] 84/17 reserved [1] 100/16 residential [1] 164/5 residents [16] 13/10 15/18 16/13 61/17 61/18 61/19 66/8 75/19 88/16 100/10 100/13 125/2 134/1 134/23 165/2 181/21 resilience [1] 82/16 resolve [1] 55/8 resolved [3] 35/9 37/7 37/11 resonate [1] 105/22 resource [2] 163/16 200/18 resourced [3] 200/17 202/18 202/21 resources [5] 93/4 113/24 152/9 181/11 196/23 resourcing [1] 201/17	respect [4] 33/19 73/20 80/18 200/20 respected [1] 54/19 respective [2] 34/23 152/3 respectively [1] 35/15 respiratory [1] 135/25 respond [3] 48/14 54/21 143/25 responding [1] 151/10 response [10] 2/19 49/4 65/18 66/22 71/22 93/15 109/11 151/14 151/16 172/3 responsibilities [6] 4/18 71/25 72/2 99/21 109/19 109/20 responsibility [12] 2/19 11/25 40/8 43/11 53/18 71/20 110/14 146/17 148/10 149/19 150/1 150/17 responsible [29] 3/5 4/2 4/8 6/22 11/15 11/18 24/17 27/21 40/5 44/4 64/13 66/13 67/2 108/21 109/15 109/22 111/3 125/23 134/12 136/8 137/3 150/17 152/5 152/6 160/10 161/24 164/18 164/23 176/6 responsive [3] 100/25 101/16 112/9 rest [4] 15/14 56/3 94/21 104/14 restrictions [2] 5/6 16/3 result [3] 7/16 54/15 105/12 resulted [1] 153/5 retained [1] 12/1 retrospectively [1] 154/4 return [3] 63/8 107/6 160/21 returning [1] 81/13 returns [1] 128/8 review [7] 31/11 71/7 71/8 77/13 170/10 172/6 181/2 revisions [1] 79/3 Richard [3] 2/23 3/21 67/25 Richardson [6] 34/5 63/15 63/17 63/22 106/19 210/8 right [80] 2/3 3/14 3/16 4/3 8/18 10/8 12/6 12/12 16/17 17/20 21/16 22/14	25/13 26/6 27/20 29/11 31/2 31/6 31/21 32/15 33/4 33/8 33/14 35/3 36/17 38/19 38/20 40/5 41/6 41/11 42/4 42/11 44/14 47/15 49/19 55/1 63/20 64/23 65/6 65/7 65/19 67/3 68/20 70/13 85/8 96/25 104/22 104/22 105/25 108/5 110/19 121/18 127/7 132/21 137/13 143/20 144/6 144/11 145/9 146/12 147/3 159/20 162/7 168/15 169/9 170/8 173/9 177/25 185/3 185/9 190/7 190/15 190/25 191/1 191/20 196/12 200/16 206/2 208/4 208/10 right-hand [1] 121/18 rights [1] 51/8 rights-based [1] 51/8 rigid [1] 114/12 rigidly [1] 43/24 riled [2] 190/3 190/4 riling [1] 190/1 rise [4] 40/1 142/12 163/10 166/4 risk [23] 20/15 29/2 37/23 39/24 40/2 42/23 44/2 44/25 45/21 47/7 47/10 76/12 85/4 134/25 136/5 157/22 160/1 160/19 170/6 171/24 188/17 205/12 207/23 risks [1] 105/17 Roberts [1] 67/25 Robin [1] 36/21 robust [2] 202/18 203/7 role [24] 4/5 4/11 9/1 25/2 43/20 44/9 48/13 65/18 66/16 66/25 67/15 68/3 71/18 108/16 108/21 108/24 109/17 109/18 110/22 111/10 112/22 127/1 174/2 179/1 roles [1] 111/5 roll [2] 7/10 44/5 rolled [2] 17/8 138/18 rollout [22] 3/25 10/16 13/18 16/19 18/13 28/5 36/16 45/16 64/18 66/1 66/4 66/10 73/2 86/14 105/5 121/14 124/10 128/16 138/20 140/23 146/10 146/14 rolls [1] 138/9	Roma [5] 54/5 106/3 190/16 193/15 193/21 room [2] 194/18 196/7 rooted [1] 157/17 roundtables [1] 201/3 route [4] 64/24 98/22 145/9 173/19 routes [3] 170/15 175/3 175/10 routine [27] 18/10 31/5 111/24 150/1 150/17 150/18 152/14 152/21 153/6 153/22 165/24 167/21 171/16 179/3 179/5 180/3 184/24 193/17 198/10 202/1 202/13 202/18 202/22 203/8 204/3 204/4 207/24 routinely [5] 19/23 19/24 144/2 169/1 169/4 roving [1] 121/24 Rowlands [2] 67/1 71/10 Royal [1] 57/7 RSV [1] 129/7 run [2] 12/16 131/20 running [8] 11/18 67/21 110/11 117/11 180/13 180/21 202/21 206/12 runs [2] 63/25 107/22 rural [15] 10/14 12/16 43/6 43/8 43/21 45/4 45/10 45/13 45/17 81/7 92/9 92/13 130/9 131/5 180/20 rurality [5] 44/16 130/24 131/12 131/13 131/15
			S	
			Sadie [1] 145/1 safe [6] 87/5 101/9 104/14 205/5 205/17 206/17 safely [1] 68/16 safer [1] 81/20 safety [12] 19/5 46/23 68/18 69/4 69/10 69/12 69/16 87/3 102/4 103/23 104/6 138/5 SAGE [1] 99/7 said [19] 20/7 21/24 24/9 27/20 28/18 33/20 35/20 47/2 56/9 57/12 60/23 105/9 106/20 131/11 147/2 160/13 179/10 190/6 208/23	

S	schemes [1] 140/19	season [1] 4/24	162/11 162/12 183/25	183/14 184/18 205/3
SAIS [3] 46/12 166/1 167/19	school [21] 26/19 46/12 86/19 86/20 143/14 144/10 144/19 144/25 145/3 165/23 165/24 166/2 166/4 166/5 166/12 167/10 167/11 167/22 168/3 168/3 168/5	seasonal [4] 4/24 7/11 112/1 129/6	186/12 198/7	servicing [1] 124/7
same [19] 15/17 16/12 28/13 37/1 41/22 45/2 45/5 60/7 89/18 100/10 130/9 130/9 134/2 151/4 163/17 165/3 178/18 181/21 188/21	school-aged [2] 165/24 168/3	seated [1] 197/6	self-declared [1] 42/19	set [25] 7/4 7/21 12/14 13/13 22/8 39/8 41/21 50/21 51/3 55/25 72/6 72/13 87/25 88/9 100/8 103/24 110/20 114/6 127/11 138/4 148/7 150/21 174/14 192/11 200/20
sanctuary [1] 90/7	schoolchildren [1] 26/19	second [4] 36/22 99/5 140/3 199/23	self-evident [4] 43/7 162/8 186/12 198/7	set-up [1] 7/21
Sandra [1] 145/2	schools [7] 46/19 166/14 166/20 167/6 167/13 168/9 168/14	secondary [1] 183/5	self-evidently [1] 52/7	sets [5] 51/13 79/8 79/10 79/14 148/5
SARS [1] 16/18	science [1] 129/22	seconded [1] 65/17	self-identification [4] 161/22 162/10 162/11 162/12	setting [6] 4/19 6/23 26/5 48/10 109/6 201/18
SARS-CoV-2 [1] 16/18	scientific [2] 74/3 120/14	secondly [3] 56/10 147/12 206/6	sell [1] 160/19	settings [1] 61/15
sat [3] 2/24 19/16 74/16	Scientist [1] 6/17	seconds [1] 36/2	send [1] 96/14	settlement [2] 25/15 27/19
satisfied [1] 128/15	scientists [1] 6/17	Secretary [11] 3/11 3/12 25/5 25/16 26/7 26/10 30/25 31/15 33/6 40/25 57/3	sending [1] 59/10	seven [7] 19/7 56/4 70/4 71/16 121/21 147/24 182/9
saw [5] 31/25 35/12 101/13 170/13 173/5	scope [1] 179/2	section [5] 78/13 79/7 86/10 146/5 168/16	senior [19] 1/17 4/2 4/8 27/21 64/13 65/10 66/13 67/1 71/10 74/15 108/7 108/18 108/21 109/15 109/22 111/3 125/23 134/12 137/3	seventies [1] 44/23
say [63] 2/12 5/18 12/18 14/6 14/16 23/14 26/14 27/4 34/10 35/6 37/13 39/19 41/19 44/13 44/21 44/24 46/17 52/22 63/21 64/8 67/23 74/5 75/9 75/25 84/23 89/22 107/17 113/12 114/22 115/16 120/1 124/21 131/7 131/11 132/13 134/18 136/8 137/2 139/9 143/2 146/19 147/15 147/21 152/7 154/13 159/14 163/23 169/13 169/16 170/17 171/3 171/7 172/17 173/8 176/9 177/23 203/9 203/10 204/13 205/4 205/9 206/1 207/10	Scotland [82] 2/5 2/6 2/10 2/13 6/18 7/5 9/4 9/10 9/13 9/19 11/4 11/22 12/8 12/15 13/6 13/8 14/1 14/4 14/5 22/23 23/3 24/19 25/8 26/13 26/17 26/18 26/20 27/3 27/5 27/10 30/20 30/25 35/14 36/5 38/1 38/4 40/9 40/15 41/13 41/20 41/20 41/21 43/6 46/14 47/14 47/18 48/11 48/12 49/10 55/1 55/5 63/3 77/14 130/9 141/24 148/21 161/6 161/10 165/1 165/21 166/8 168/19 171/12 172/21 172/24 173/7 179/17 180/2 180/10 180/18 180/24 181/18 181/20 181/22 183/23 184/8 190/8 190/17 191/5 200/21 201/8 201/9	sectoral [3] 5/3 154/11 185/15	send [1] 96/14	several [1] 66/1
saying [9] 59/3 59/14 86/11 88/5 117/23 139/11 177/2 196/10 201/11	Scottish [26] 1/16 3/8 3/24 4/9 6/19 7/5 7/18 20/8 25/9 30/13 37/12 37/13 45/15 45/24 48/16 50/9 53/4 54/2 56/1 57/24 58/6 59/20 59/25 61/13 62/3 180/19	sectorially [1] 145/16	sense [12] 5/13 16/11 16/17 18/25 25/9 43/25 89/24 128/1 145/7 180/6 202/7 205/21	severe [4] 97/4 98/2 158/3 163/5
says [5] 13/6 13/25 14/16 34/6 36/21	scratch [1] 20/22	sectors [3] 28/7 66/4 164/14	sensible [2] 78/10 162/8	severity [1] 160/1
scale [4] 17/11 17/22 79/14 100/24	screen [2] 85/10 161/5	secure [1] 193/18	sensitivity [1] 163/24	sex [1] 186/23
scale-up [1] 17/11	screening [2] 1/24 55/22	secured [2] 23/15 23/17	sent [2] 59/16 102/11	shall [4] 63/8 107/6 160/21 177/22
scanning [1] 81/15	script [1] 42/18	security [2] 7/1 57/4	separate [2] 78/10 134/9	share [6] 24/5 36/24 72/9 74/21 75/8 76/10
scenario [4] 78/20 201/25 202/1 206/16	scroll [3] 7/7 8/24 79/7	see [30] 7/9 8/25 21/24 22/3 27/24 37/1 38/25 39/12 51/16 52/2 62/12 62/22 81/14 82/17 86/7 92/2 99/11 118/11 121/10 121/17 121/24 135/6 137/1 148/12 153/4 162/3 163/21 176/18 178/15 206/25	share [6] 24/5 36/24 72/9 74/21 75/8 76/10	shared [5] 64/17 77/12 89/13 89/25 91/3
schedule [1] 21/9	scrutinised [1] 43/18	seeing [4] 52/19 102/10 102/14 150/21	September [4] 17/18 149/24 181/19 186/6	sharing [2] 51/25 90/1
scheduling [1] 82/20		seek [2] 42/19 69/22	September 2020 [2] 149/24 181/19	sharper [1] 191/3
scheme [17] 100/20 100/23 101/14 101/19 101/21 101/23 102/3 102/7 102/12 102/19 139/10 140/7 140/10 159/10 159/12 162/25 201/1		seeker [1] 91/20	September 2021 [1] 186/6	she [10] 31/18 31/19 33/5 36/20 36/21 85/14 110/9 110/18 110/19 110/22

S	45/22 47/23 48/23 49/8 53/10 118/21 121/21 122/9 147/11 171/3 173/17 173/24 178/5 192/13 205/4 206/2 sitting [2] 30/22 125/24 situation [4] 86/24 89/18 125/16 198/22 six [3] 90/9 101/4 127/17 sixties [2] 44/23 75/9 size [4] 41/18 74/23 113/19 130/7 skating [1] 190/23 skill [1] 110/20 skill set [1] 110/20 skills [1] 172/14 slavery [1] 105/14 sleeping [2] 169/15 170/2 sliding [1] 100/24 slight [1] 186/4 slightly [6] 26/20 47/18 95/20 96/2 141/5 156/9 slim [1] 116/18 slim-lined [1] 116/18 slimmed [1] 84/24 slow [4] 8/19 15/7 15/8 124/10 slowed [2] 23/12 172/4 slower [2] 8/22 24/7 slowly [1] 124/24 small [7] 59/8 60/5 66/19 67/10 110/9 111/7 174/10 smaller [2] 132/10 206/2 smallpox [1] 98/24 so [375] social [46] 3/13 25/5 25/17 25/18 25/22 31/16 44/12 51/23 57/4 57/13 66/8 99/7 100/1 112/22 113/1 113/3 113/4 113/11 124/15 125/3 125/5 125/9 125/18 125/20 128/9 130/21 134/22 135/5 135/7 135/24 137/8 140/15 148/21 156/15 164/1 164/2 164/8 164/10 164/12 164/19 172/1 174/1 183/13 191/12 197/14 206/13 socially [2] 130/12 158/6 societal [1] 165/13 society [3] 120/9 121/5 161/25	socioeconomic [3] 190/20 191/1 191/18 socioeconomically [1] 158/18 sole [1] 161/19 solutions [1] 197/25 solve [1] 198/5 solved [1] 31/9 some [100] 1/14 1/24 5/15 11/1 11/24 17/10 18/23 22/3 24/21 24/22 26/17 26/23 27/24 28/13 29/2 29/17 30/8 30/16 30/17 34/1 36/8 36/14 37/22 37/24 42/9 44/21 52/18 53/4 53/24 54/12 56/17 57/16 57/21 58/7 58/8 58/14 58/24 59/1 59/2 59/5 59/7 59/16 59/25 63/24 66/5 66/12 69/9 71/8 74/24 81/6 84/2 85/19 85/25 92/21 93/5 94/1 94/8 96/1 96/8 97/22 98/18 99/11 103/16 105/10 105/11 107/21 109/6 109/7 118/19 123/3 130/12 130/23 131/9 132/14 142/3 146/7 146/16 147/1 151/25 156/16 161/24 162/5 162/13 167/25 168/20 170/16 173/20 174/25 175/23 178/21 178/22 180/19 180/20 187/24 193/4 195/20 196/1 198/25 199/1 201/21 somebody [11] 13/15 14/16 42/18 42/20 42/23 56/16 56/17 60/15 83/16 101/2 101/3 someone [2] 30/21 134/5 something [24] 11/22 27/17 32/13 33/16 43/22 87/11 113/1 113/15 126/1 126/4 130/19 132/5 132/18 134/17 139/22 147/21 153/20 154/22 162/23 163/18 165/15 181/22 183/18 186/2 sometimes [14] 19/7 24/6 43/18 56/16 58/13 60/19 69/3 69/14 73/3 73/22 93/15 94/23 119/17 176/8 somewhere [1] 201/11 soon [4] 18/24 19/15	34/21 95/7 sooner [2] 20/18 21/3 sophisticated [2] 132/19 139/12 sorry [16] 15/6 25/23 62/15 86/8 91/17 91/23 131/10 131/15 142/2 142/4 142/7 148/9 156/10 160/22 190/2 203/16 sort [16] 67/9 72/19 87/12 87/22 99/2 108/25 109/6 118/11 122/15 122/16 123/21 126/4 126/16 127/17 139/15 139/17 sorting [1] 57/7 sorts [1] 62/4 sought [3] 49/19 51/7 54/21 sound [2] 32/2 43/22 sounds [1] 156/23 sources [4] 28/21 36/9 97/10 104/5 space [3] 48/2 77/22 179/15 spaces [1] 93/25 spade [2] 166/13 166/13 speak [3] 56/16 119/25 203/4 speaking [7] 15/7 15/21 19/19 39/21 42/24 60/6 190/11 special [1] 71/17 specialism [1] 108/5 specialist [6] 70/4 70/5 103/9 103/10 123/8 148/24 specific [13] 17/6 37/25 75/5 125/24 131/6 158/1 158/19 175/2 178/10 179/13 193/4 201/18 204/6 specifically [5] 50/18 132/9 137/24 176/11 183/19 specifics [1] 208/2 sped [1] 95/2 speed [2] 30/13 81/5 speedily [2] 170/15 202/24 speedy [1] 179/24 spent [2] 169/17 169/17 sphere [4] 30/7 129/5 135/5 135/23 spirit [1] 28/11 split [1] 87/23 spoke [1] 174/23 spoken [2] 104/25 181/11 Sport [2] 3/11 41/1	spread [2] 89/9 139/20 SRO [5] 4/11 24/5 32/7 71/11 109/18 SROs [12] 24/4 32/17 34/21 62/25 67/5 76/17 77/12 115/4 115/6 115/9 115/10 118/6 SSE [1] 127/12 staff [20] 15/17 16/12 18/1 18/21 49/18 52/5 61/17 67/19 82/15 104/6 121/23 124/15 125/2 125/3 133/10 133/16 133/20 176/6 181/21 196/23 staffing [1] 67/13 stage [4] 69/18 69/19 94/22 150/4 stages [1] 95/2 stakeholder [4] 70/12 72/20 87/21 97/9 stakeholders [4] 68/8 70/10 88/2 148/10 stand [1] 58/12 stand-up [1] 58/12 standard [4] 22/16 104/2 156/16 192/3 standardised [1] 187/5 standards [1] 156/16 standing [3] 108/17 183/25 192/7 standpoint [1] 150/21 starker [1] 86/5 start [19] 1/14 8/3 10/11 10/16 14/21 19/25 32/19 44/7 44/11 56/23 58/20 94/25 114/6 146/4 147/8 154/18 154/22 175/24 196/2 start-up [1] 175/24 started [10] 13/19 29/19 38/7 51/2 124/4 148/3 166/7 167/19 172/5 176/3 starting [5] 15/1 19/7 38/1 110/5 114/24 starts [2] 27/6 148/9 state [11] 19/9 25/5 25/16 26/7 26/10 30/25 31/15 33/6 35/13 53/25 202/14 stated [3] 31/18 31/19 57/25 statement [31] 1/13 5/18 7/3 20/7 22/12 25/3 26/3 47/2 55/24 57/12 63/25 64/2 64/3
----------	---	---	---	---

S	statement... [18] 67/10 67/20 68/12 68/13 68/14 68/18 74/25 77/11 84/2 94/12 105/8 107/22 107/24 107/25 117/17 121/13 126/1 138/1 states [5] 15/13 41/11 79/16 83/25 160/6 stations [1] 84/22 statistical [3] 145/15 153/14 154/24 statisticians [1] 76/4 statistics [5] 28/5 41/12 154/9 154/10 185/11 status [10] 73/20 88/15 89/19 91/7 133/21 159/6 161/8 190/20 193/19 208/15 statute [1] 157/4 statutory [2] 26/9 41/25 stay [1] 13/11 steer [2] 175/18 175/19 Steering [2] 50/21 179/18 stenographer [3] 8/23 91/18 131/14 step [1] 102/22 Stephenson [5] 63/13 104/17 104/18 107/10 132/24 stepped [1] 49/3 stepping [3] 65/18 67/15 68/2 steps [6] 92/10 198/5 200/21 200/23 205/16 206/6 stewards [1] 49/8 stick [1] 43/24 still [12] 7/18 55/6 90/16 115/1 129/3 129/8 129/10 136/21 180/21 193/5 195/16 197/24 stock [4] 23/18 28/6 95/4 95/5 stop [1] 155/1 storage [2] 79/25 117/1 stored [4] 81/1 194/17 207/25 207/25 storing [1] 174/8 storm [2] 141/24 142/1 straight [3] 10/4 32/21 80/24 straightforward [1] 159/13	strain [1] 16/18 strange [1] 102/15 strategic [3] 117/25 177/6 182/22 strategies [5] 29/15 146/21 155/16 159/1 175/2 strategy [19] 31/12 31/17 32/1 32/3 32/6 33/1 73/9 78/6 78/25 79/6 79/10 79/16 82/9 83/24 85/11 100/8 119/21 120/25 184/14 stratification [1] 157/9 stratified [1] 157/14 streamlined [1] 166/18 strength [2] 74/5 78/11 stress [1] 5/16 stress-test [1] 5/16 stresses [1] 134/7 strict [1] 80/25 strictly [1] 98/2 strides [1] 193/4 strong [3] 147/17 189/14 202/18 strongly [1] 169/21 structural [2] 195/21 196/1 structure [8] 5/2 9/25 11/15 11/21 41/25 70/5 76/5 152/2 structures [10] 5/11 50/17 72/5 96/20 112/10 116/4 116/17 116/20 147/10 184/19 stuff [1] 78/2 Sturgeon [1] 3/10 sub [1] 68/24 sub-prioritisation [1] 68/24 subgroup [1] 70/9 subgroups [5] 69/24 70/1 70/4 70/6 74/3 subject [6] 72/11 138/8 143/5 144/18 171/6 197/20 submission [1] 40/24 submitting [1] 187/23 subpopulation [1] 154/11 subscribed [1] 89/23 subsequently [2] 28/19 31/3 substance [4] 32/12 88/14 93/17 191/14 subtle [6] 26/17 29/23 30/2 60/5 60/20 122/18 success [1] 153/9 successful [3]	129/18 131/9 153/12 such [27] 1/24 12/21 24/12 55/7 68/18 69/15 72/7 87/18 105/11 105/21 111/2 111/25 120/18 127/19 129/7 131/8 139/25 140/6 148/14 159/5 159/8 160/6 172/21 177/12 177/14 188/10 208/15 suddenly [1] 198/22 suffer [1] 163/3 suffered [1] 193/8 suffering [2] 163/9 181/4 sufficient [5] 73/11 119/18 150/12 152/9 178/7 sufficiently [4] 102/6 149/15 173/15 193/23 suggest [5] 10/6 148/11 173/6 203/25 204/2 suggestion [1] 117/22 suggestions [1] 75/25 suggests [2] 10/4 50/11 suitable [1] 205/5 suite [1] 40/10 summaries [1] 103/4 summarise [1] 203/4 summarised [1] 166/8 summarises [1] 85/18 summary [5] 70/23 80/19 103/21 144/7 166/9 summation [1] 94/18 super [1] 166/14 supervised [1] 171/10 supervising [1] 85/13 supervision [2] 16/2 170/22 suppliers [1] 90/11 supplies [8] 11/12 23/24 24/11 58/5 80/22 124/24 173/5 173/7 supply [35] 6/24 10/22 10/24 11/8 14/22 15/6 15/11 23/8 23/20 23/22 24/2 24/5 24/12 30/8 31/4 35/1 35/5 35/6 36/5 36/9 37/11 58/1 79/12 79/17 79/22 80/5 80/8 80/11 113/14 113/15 146/23 147/9 159/22	160/8 172/20 supplying [1] 14/2 support [18] 9/4 9/5 43/13 45/6 45/12 48/8 49/13 49/19 50/5 54/14 67/24 68/1 77/5 101/6 101/11 140/6 143/23 207/10 supported [7] 6/13 15/4 24/9 61/2 167/12 180/8 182/17 supporting [6] 9/11 43/17 52/17 84/8 127/2 171/16 supportive [1] 48/20 suppose [7] 6/16 18/11 39/16 61/4 61/16 139/2 180/16 supposing [1] 80/6 sure [45] 13/1 13/22 21/1 23/24 26/24 28/9 32/24 38/13 38/16 52/9 55/6 55/9 59/15 59/16 79/12 84/12 84/22 100/12 106/13 109/21 110/3 110/5 110/20 110/23 112/9 113/23 134/13 135/24 136/3 136/6 137/5 137/14 140/25 147/19 151/3 151/17 151/21 153/1 162/6 167/2 171/5 171/21 174/15 182/3 208/23 surgeries [6] 11/5 12/19 39/4 81/17 161/14 180/22 surgery [5] 167/5 169/9 169/12 178/5 178/17 surprise [1] 86/12 surrounding [1] 179/11 surveillance [9] 64/16 70/2 85/6 102/8 102/24 102/25 103/6 139/9 140/23 suspect [3] 35/16 54/8 133/6 suspected [1] 96/24 suspend [2] 69/4 104/12 suspended [1] 104/13 suspicion [2] 26/15 35/5 Swann [1] 36/21 swiftly [2] 68/15 80/13 switched [1] 104/21 sworn [7] 1/6 63/16 107/12 142/15 142/18 210/3 210/19 sync [1] 36/4	syndrome [2] 97/15 163/6 system [74] 8/13 8/13 12/3 12/8 12/11 20/5 20/21 20/25 21/10 21/13 21/17 22/6 22/9 22/11 24/12 24/14 25/4 27/25 29/24 37/9 42/21 42/24 43/2 43/7 53/25 55/20 56/7 60/7 60/12 80/8 82/18 82/22 82/23 83/2 83/4 83/9 96/23 114/13 125/4 125/5 125/20 125/22 126/20 126/20 127/23 128/2 128/5 128/13 128/16 128/22 129/1 148/23 156/22 161/17 162/9 162/18 164/22 166/12 170/21 171/15 172/9 173/1 173/6 178/9 180/12 180/16 183/2 192/9 193/24 194/5 194/7 194/9 202/21 207/6 systems [30] 8/12 11/17 11/17 19/9 19/18 20/9 20/14 20/15 34/23 83/17 84/16 91/15 126/25 128/7 140/6 145/11 156/20 168/25 192/7 192/8 192/19 192/24 193/1 193/2 193/11 194/4 194/11 204/4 207/13 207/19
			T		
			table [4] 47/18 148/4 148/4 175/12 tabled [1] 51/2 tabletop [2] 66/10 66/12 tackled [1] 181/9 tail [1] 62/8 tailor [1] 177/1 tailored [13] 17/5 44/6 154/14 175/10 175/20 176/16 177/15 178/10 179/13 180/11 201/8 201/19 208/17 take [49] 5/10 6/22 6/25 16/6 20/4 21/16 21/19 39/3 45/9 46/6 47/9 50/10 50/13 53/23 54/7 56/22 79/5 83/23 86/10 100/3 100/6 101/1 118/4 133/16 134/21 138/4 144/4 144/5 153/14 153/17 155/23 155/24 156/1 158/13 160/22 180/1 182/1 185/13		

T	teams [14] 43/20 54/12 62/20 77/3 82/11 85/20 86/13 121/22 123/23 124/3 125/13 125/14 167/11 178/5	158/1 173/6 173/16 176/17 177/10 179/1 184/6 186/1 186/7 186/13 189/1 191/3 199/11 199/24 207/23	43/15 48/22 52/15 57/14 59/12 60/16 60/22 60/24 61/3 61/3 69/10 69/25 72/1 72/9 75/23 80/9 82/13 83/13 83/14 83/15 83/15 83/15 88/23 89/12 90/4 90/5 91/2 92/12 92/15 92/17 93/4 94/5 95/12 95/20 96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
take... [11] 186/13 186/23 187/13 188/13 188/21 189/10 191/13 192/2 195/13 196/8 198/5	technical [3] 35/8 43/23 123/12	thank [69] 1/11 1/11 7/8 10/2 14/14 32/21 34/4 36/1 62/24 63/3 63/4 63/6 63/8 63/23 64/6 64/11 83/23 86/10 92/3 104/16 104/17 105/24 106/17 106/18 106/19 107/1 107/2 107/4 107/19 108/3 118/4 122/4 122/19 122/20 132/23 132/24 133/3 134/4 136/15 137/9 137/11 137/17 138/24 140/2 141/8 141/9 141/10 141/12 141/16 141/20 141/22 142/9 142/10 142/25 143/1 166/3 190/7 204/16 204/17 204/20 206/22 206/23 207/3 208/19 208/20 208/21 209/2 209/4 209/5	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
take-up [21] 6/25 20/4 21/19 50/13 100/3 100/6 144/4 144/5 153/14 153/17 155/23 155/24 156/1 185/13 186/13 186/23 187/13 188/21 189/10 191/13 192/2	technicians [1] 127/16	that [1194] that I [9] 62/20 73/22 109/13 109/21 115/18 128/11 130/6 134/17 204/19	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
taken [21] 6/1 7/17 18/22 24/16 51/7 69/13 88/4 102/22 112/6 131/23 148/1 152/1 152/1 157/16 165/1 165/7 178/21 200/22 205/17 206/6 206/13	temporarily [2] 1/17 104/11	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 166/9 167/3 167/20 168/19 169/5 177/4 180/16 182/21 183/16 187/25 190/1 196/22 200/10 200/16 200/18 202/5 203/10 208/1	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
taking [7] 37/21 37/22 52/15 105/17 137/22 167/4 199/14	tend [1] 198/10	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 166/9 167/3 167/20 168/19 169/5 177/4 180/16 182/21 183/16 187/25 190/1 196/22 200/10 200/16 200/18 202/5 203/10 208/1	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
talk [5] 94/2 103/12 175/22 189/15 196/8	tends [1] 10/5	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 166/9 167/3 167/20 168/19 169/5 177/4 180/16 182/21 183/16 187/25 190/1 196/22 200/10 200/16 200/18 202/5 203/10 208/1	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
talked [10] 30/6 54/11 95/1 98/24 111/3 120/24 146/13 175/13 178/23 201/23	tension [1] 6/8	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 166/9 167/3 167/20 168/19 169/5 177/4 180/16 182/21 183/16 187/25 190/1 196/22 200/10 200/16 200/18 202/5 203/10 208/1	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
talking [9] 36/9 152/16 153/22 171/19 175/12 181/13 182/22 200/18 202/8	tensions [1] 28/24	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 166/9 167/3 167/20 168/19 169/5 177/4 180/16 182/21 183/16 187/25 190/1 196/22 200/10 200/16 200/18 202/5 203/10 208/1	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
talks [4] 13/3 13/5 13/18 183/16	term [3] 27/5 73/5 119/12	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 166/9 167/3 167/20 168/19 169/5 177/4 180/16 182/21 183/16 187/25 190/1 196/22 200/10 200/16 200/18 202/5 203/10 208/1	96/10 96/18 97/20 98/9 99/5 99/5 99/20 100/22 101/6 103/22 104/8 111/22 112/13 118/16 118/20 119/16 124/6 124/6 126/10 126/24 127/3 133/9 134/1 135/9 145/13 145/20 146/1 147/24 157/15 165/2 166/25 167/2 168/8 171/18 173/4 173/10 173/23 175/16 176/17 177/16 178/14 179/12 182/21 182/23 184/22 189/1 189/19 198/2 207/9	122/11 123/16 123/16 123/18 124/2 124/3 124/17 124/18 126/13 128/6 128/7 138/8 139/8 139/18 140/19 140/20 141/2 141/2 141/6 145/15 145/17 147/12 148/19 153/6 154/20 156/25 162/19 162/20 164/22 165/11 165/17 170/14 171/2 171/17 173/24 174/7 177/2 177/4 178/5 178/22 180/5 181/11 181/15 185/3 186/21 186/23 187/13 190/8 191/21 198/15 199/24 200/6 200/21
target [4] 42/11 46/2 82/14 129/24	terms [47] 1/22 6/12 8/9 23/21 26/11 46/16 69/10 71/4 71/18 71/19 74/20 76/13 83/13 88/7 90/3 97/18 97/19 98/9 102/5 103/23 118/19 119/6 120/8 128/9 128/17 140/9 140/18 141/3 145/11 147/6 150/12 151/22 152/10 152/16 157/12 157/15 158/9 158/11 165/19 169/17 170/14 173/7 184/19 194/3 197/21 198/4 202/11	that's [82] 2/4 3/2 3/6 3/14 3/16 4/1 4/3 4/17 10/9 12/18 14/10 14/10 14/15 15/19 16/4 31/1 31/13 31/22 36/17 38/15 39/13 40/4 42/3 43/6 44/19 45/10 55/2 60/25 63/20 65/1 65/7 65/12 67/3 72/18 81/20 88/19 99/2 102/22 108/12 113/1 114/1 115/25 116/24 122/15 127/7 128/1 132/5 132/17 136/2 139/22 143/10 143/12 143/21 144/6 144/12 144/17 144/23 145/3 148/19 154/17 156/8 156/14 157/24 160/2 1		

T	thinking [6] 51/9 162/15 176/25 181/15 206/11 206/15	39/24 42/12 43/8 45/20 48/2 56/15 60/20 60/22 62/4 62/23 66/2 67/18 69/6 70/4 70/5 74/12 74/25 76/8 86/3 86/8 88/10 88/17 90/17 90/22 91/16 93/12 93/14 93/19 94/6 95/9 97/21 97/22 98/7 101/12 103/11 104/7 104/16 105/18 106/6 111/25 115/6 117/7 117/15 124/16 125/1 125/7 125/11 126/8 126/25 129/11 130/3 130/23 130/24 130/25 131/9 131/24 132/9 132/23 135/4 135/21 137/7 137/21 137/23 140/7 140/19 145/19 149/25 151/3 151/20 155/16 158/2 158/17 158/22 159/4 161/11 161/25 163/3 163/5 163/6 163/9 164/10 169/10 169/12 170/11 172/13 175/5 175/15 177/24 182/10 183/15 189/5 189/20 191/13 191/15 192/23 192/24 193/2 193/8 193/9 193/17 193/18 196/1 198/16 198/20 200/6 201/21 204/9 204/12 206/7 206/15 208/9 208/17 208/21	57/2 57/5 57/9 62/7 64/23 68/5 72/2 80/22 81/16 81/20 83/1 85/3 90/25 94/3 113/3 116/13 117/11 117/12 131/20 138/12 139/8 139/9 158/25 165/25 166/12 166/22 171/12 173/4 178/4 180/21 180/22 192/24	115/2 182/8 209/3 together [22] 5/10 18/19 33/19 38/3 76/22 90/19 92/23 102/16 111/7 120/23 126/23 126/23 128/14 128/16 151/6 151/11 156/9 176/1 176/7 176/23 177/14 198/23	
they... [126] 52/22 57/8 60/18 60/22 60/23 60/24 72/1 72/7 72/8 72/14 72/16 80/9 80/10 80/11 80/23 82/4 84/24 86/14 86/16 88/20 91/1 91/12 92/10 93/7 93/13 94/4 94/22 94/24 95/11 95/20 96/10 97/8 99/20 99/21 101/5 103/3 103/24 104/5 104/9 111/12 111/16 111/19 111/23 112/2 112/18 112/19 112/19 112/24 112/25 112/25 114/7 117/10 118/21 118/24 118/25 119/1 122/18 123/18 124/7 124/18 124/24 125/13 125/14 126/11 126/15 127/1 127/16 127/18 127/21 130/20 130/20 131/3 131/4 131/4 131/6 135/11 137/2 140/25 142/15 146/10 147/25 149/23 150/15 150/16 152/12 155/6 157/15 157/16 157/20 159/17 159/18 160/2 161/15 161/20 165/9 167/16 168/5 169/24 173/13 173/18 173/19 173/22 174/2 174/13 174/14 174/16 175/17 177/16 178/25 180/2 181/24 181/25 182/5 183/5 184/3 184/9 185/12 185/12 188/3 188/12 191/15 197/12 197/19 198/9 199/13 200/13	third [10] 38/25 45/8 49/20 64/19 70/14 85/21 88/21 90/11 93/21 186/9	third sector [1] 45/8 third-sector [2] 49/20 64/19	together [22] 5/10 18/19 33/19 38/3 76/22 90/19 92/23 102/16 111/7 120/23 126/23 126/23 128/14 128/16 151/6 151/11 156/9 176/1 176/7 176/23 177/14 198/23		
they'd [2] 71/21 189/3	this [162] 6/1 6/4 6/7 10/5 13/3 13/9 13/17 13/20 14/18 19/21 21/6 22/12 26/12 29/9 31/11 31/14 32/2 32/19 32/23 33/1 33/2 33/6 34/14 36/7 36/21 36/25 37/5 38/23 39/1 39/16 41/3 41/10 50/1 50/11 51/12 51/16 52/7 52/16 52/23 53/15 56/22 58/10 59/20 59/24 76/10 79/3 79/6 81/23 82/2 82/9 83/6 83/7 84/6 85/3 85/11 85/12 85/18 86/13 86/19 86/23 87/5 87/5 87/7 96/16 96/17 99/3 100/3 100/22 102/19 103/12 104/22 112/3 115/16 117/23 118/5 118/8 118/17 119/23 120/6 121/3 121/13 121/19 122/5 129/20 133/23 138/6 138/15 138/19 138/22 140/3 142/14 143/4 143/22 146/8 148/6 148/11 149/9 152/15 152/16 152/20 152/22 153/22 154/1 155/9 155/12 155/22 157/23 158/24 160/6 160/8 161/23 162/17 164/24 167/1 167/21 168/10 168/10 169/7 170/10 170/18 171/1 171/4 172/17 172/17 175/11 175/22 175/25 178/11 180/25 181/13 182/1 182/2 182/24 182/25 183/9 183/10 183/10 183/18 185/6 185/21 185/23 187/2 188/13 188/16 189/2 192/4 194/1 194/11 195/4 196/24 197/3 197/10 197/22 198/22 202/10 202/21 203/19 204/1 205/15 206/9 207/7 207/21	though [8] 39/19 42/16 42/24 114/11 119/14 131/17 191/8 206/12	through [43] 8/4 11/25 13/19 16/20 17/1 18/4 18/8 21/10 38/11 46/18 55/20	time [79] 3/17 6/4 10/20 14/8 15/3 15/5 15/9 16/12 16/20 16/24 17/2 17/8 17/12 18/2 18/12 18/14 19/12 20/16 22/6 23/7 23/7 25/13 27/6 28/16 28/25 29/14 37/1 39/14 40/18 45/14 53/22 53/23 53/23 65/16 66/19 77/16 77/21 77/22 77/22 78/14 80/6 83/6 87/16 99/19 99/20 101/5 104/13 108/14 108/24 110/25 115/13 117/18 117/20 117/23 118/7 119/9 119/19 124/25 129/9 134/2 134/6 136/8 138/4 146/3 154/3 156/5 159/22 160/9 162/7 162/18 169/17 172/4 175/7 178/18 179/15 184/4 193/3 200/7 203/17	together [22] 5/10 18/19 33/19 38/3 76/22 90/19 92/23 102/16 111/7 120/23 126/23 126/23 128/14 128/16 151/6 151/11 156/9 176/1 176/7 176/23 177/14 198/23
they'll [1] 76/5	those [121] 13/10 18/20 20/14 20/16 28/24 35/2 36/8 39/14	thought [2] 17/18 114/24	throughout [1] 133/14	told [3] 21/5 102/13 103/24	
they're [8] 68/17 135/24 139/4 167/1 177/15 177/17 177/22 204/14		thoughtfully [1] 55/25	throughput [1] 127/20	tomorrow [1] 209/7	
they've [2] 91/12 92/16		thoughts [1] 117/19	throwing [2] 58/24 59/1	too [1] 172/4	
thing [7] 6/7 33/21 55/7 103/7 171/7 178/13 188/13		thousand [1] 92/20	ticked [1] 157/22	took [17] 2/7 4/21 8/4 15/5 20/16 46/19 49/10 55/11 71/9 103/1 108/21 109/18 157/20 158/7 158/21 162/4 172/3	
things [21] 28/18 51/10 53/15 56/5 62/4 70/1 73/22 91/10 95/2 105/18 109/4 114/3 114/5 116/2 119/15 122/12 130/21 132/1 181/10 201/15 206/13		three [6] 7/19 56/4 85/2 111/16 137/19 175/24	tie [1] 158/8	tool [4] 9/6 19/14 19/14 55/22	
think [250]		three years [1] 7/19	tied [1] 166/4	toolkit [1] 201/8	
		threshold [6] 69/16 100/25 187/20 188/3 199/20 200/4	tight [1] 118/22	tools [1] 40/10	
		threw [1] 58/8	tiles [2] 142/4 142/6	top [1] 82/3	
		thrombocytopenia [1] 103/19	time [79] 3/17 6/4 10/20 14/8 15/3 15/5 15/9 16/12 16/20 16/24 17/2 17/8 17/12 18/2 18/12 18/14 19/12 20/16 22/6 23/7 23/7 25/13 27/6 28/16 28/25 29/14 37/1 39/14 40/18 45/14 53/22 53/23 53/23 65/16 66/19 77/16 77/21 77/22 77/22 78/14 80/6 83/6 87/16 99/19 99/20 101/5 104/13 108/14 108/24 110/25 115/13 117/18 117/20 117/23 118/7 119/9 119/19 124/25 129/9 134/2 134/6 136/8 138/4 146/3 154/3 156/5 159/22 160/9 162/7 162/18 169/17 172/4 175/7 178/18 179/15 184/4 193/3 200/7 203/17	timeframe [1] 31/20	topic [11] 10/5 50/9 98/11 137/25 143/5 143/7 157/1 161/2 192/5 202/10 204/15
		thrombosis [1] 103/19	timeliness [1] 101/16	total [4] 23/16 70/4 74/20 185/24	
		through [43] 8/4 11/25 13/19 16/20 17/1 18/4 18/8 21/10 38/11 46/18 55/20	times [11] 23/22 23/23 26/3 26/23 28/12 28/14 30/9 80/25 84/20 95/17 205/24	totality [1] 23/18	
			timescale [2] 118/2 118/22	touch [3] 53/5 96/14 190/25	
			timescales [1] 119/17	touched [4] 73/10 151/3 175/21 182/2	
			timing [1] 25/20	Touching [1] 108/3	
			today [11] 1/4 1/12 18/18 57/25 65/8 107/19 111/4 113/17	touchpoints [1] 171/19	
				towards [6] 8/25 117/25 154/8 159/11 172/18 203/9	
				Trace [1] 66/21	
				Tracey [7] 142/15 142/18 142/24 156/12 167/15 185/7 210/19	
				Tracey Chantler [1] 142/24	
				track [5] 85/7 126/2 126/9 126/17 178/15	
				tracking [1] 8/13	
				traditional [1] 87/4	
				traditionally [1] 54/17	
				train [5] 40/21 49/18 69/19 171/9 172/7	
				trained [6] 49/1 49/4 50/3 50/7 104/7 172/2	
				training [11] 19/4 40/5 40/10 40/14 40/17 52/5 84/8 102/13 171/18 171/22 172/12	
				transfer [3] 11/4 81/10 81/12	

T	trust-led [1] 178/4	173/11 179/8 187/22	21/19 35/3 74/6 80/14	untenable [1] 36/24
transferred [1] 70/20	trust/school [1] 167/11	191/23 194/13 194/22	80/17 80/20 101/15	until [14] 6/2 20/3
transformation [8] 7/17 7/22 7/24 8/1 8/2 8/6 8/8 180/14	trusted [9] 53/7 54/18 87/17 89/9 106/1 106/5 106/6 110/17 198/24	UK Government [11] 23/15 31/3 32/5 33/11 33/17 77/12 78/4 79/11 100/17 173/11 187/22	183/6 183/13 184/22 192/2	36/13 38/10 38/13 38/13 44/8 46/17 66/14 104/11 109/5 149/23 167/16 209/9
translated [1] 78/2	trusting [1] 196/20	UK Government-led [1] 113/15	understatement [1] 36/6	untrue [1] 30/9
translates [1] 25/25	trusts [7] 71/17 112/16 112/21 112/22 112/24 113/4 121/21	UK-led [1] 68/17	understood [3] 26/22 26/24 30/3	unusual [1] 129/1
translation [1] 89/4	truth [2] 64/2 107/24	UK-wide [2] 33/7 194/13	undertake [1] 207/8	unvaccinated [2] 133/10 133/25
transmission [3] 158/9 189/13 205/12	try [13] 42/22 58/7 104/22 110/10 132/10 134/10 135/14 135/20 136/22 139/3 144/21 198/5 199/9	UKHSA [5] 25/24 103/4 149/21 149/25 153/20	undertaken [1] 26/1	unviable [1] 81/10
transmitted [1] 105/25	trying [13] 50/19 53/22 55/23 120/7 124/13 134/8 139/2 139/12 153/21 154/5 156/9 158/24 197/21	ultimately [12] 4/10 10/13 12/1 31/8 35/8 158/25 162/17 163/15 163/21 163/22 167/5 173/3	undesirability [1] 35/24	up [129] 4/19 6/2 6/10 6/23 6/25 7/21 8/13 12/14 13/13 14/23 15/20 17/11 17/22 20/4 20/13 21/9 21/14 21/15 21/19 22/8 22/25 23/20 29/25 31/24 37/10 37/12 40/13 40/16 41/10 42/18 45/8 46/17 47/16 48/10 50/3 50/13 50/21 54/7 55/21 58/12 59/2 59/7 60/7 62/8 62/9 70/13 72/6 78/18 79/13 81/5 81/24 85/10 87/10 87/16 87/25 88/9 89/8 95/2 100/3 100/6 108/24 109/5 110/11 111/1 114/7 116/16 117/10 122/13 127/11 127/21 128/8 133/16 134/15 135/2 140/24 144/4 144/5 146/7 149/2 150/21 153/14 153/17 155/23 155/24 156/1 158/9 159/10 161/5 164/13 164/21 168/4 170/12 170/13 170/16 171/9 173/3 174/10 174/14 175/14 175/24 177/17 180/13 181/8 184/11 185/13 186/6 186/13 186/23 187/13 188/11 188/21 189/10 191/6 191/13 192/2 192/7 192/11 193/20 194/13 194/21 195/13 197/25 200/3 201/5 201/18 202/21 204/10 206/11 208/12
transparency [2] 87/2 138/12	Tuesday [1] 1/1	ultra [1] 123/6	unfair [3] 30/11 36/14 44/13	update [2] 32/4 128/18
transparent [1] 77/6	turn [5] 37/20 59/12 162/24 185/3 186/24	umbrella [2] 204/14 207/22	unhelpful [1] 30/9	updated [2] 25/14 40/20
transport [6] 48/11 52/4 64/17 89/8 93/10 195/7	turned [2] 48/15 147/14	unable [6] 36/14 36/24 37/6 37/8 45/20 101/6	unique [3] 86/25 113/2 113/2	upload [1] 19/20
transporting [2] 49/23 174/8	Turning [3] 50/9 113/14 207/15	unattributed [4] 28/20 30/12 30/16 36/8	unique-ish [1] 113/2	uploaded [1] 19/17
travel [3] 44/18 45/20 60/17	turnover [1] 99/25	unbottling [1] 84/18	unit [3] 67/25 68/2 144/16	upon [4] 25/17 73/25 161/22 175/9
Traveller [5] 54/5 106/3 190/16 193/15 193/22	twin [4] 126/2 126/9 126/17 178/15	uncertain [3] 88/15 89/19 91/7	United [23] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 56/6 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	upper [1] 187/7
travelling [1] 45/21	twin-track [2] 126/9 126/17	under [12] 13/6 16/1 30/15 47/24 77/25 92/20 170/22 171/2 186/3 186/17 186/18 197/12	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	upskilled [1] 171/17
trays [2] 11/3 92/20	two [23] 7/19 65/3 69/17 75/7 96/4 105/18 111/5 124/23 126/25 134/9 137/1 142/12 142/13 145/4 150/9 165/4 186/7 186/11 187/9 187/16 188/2 200/6 205/14	under-5s [1] 186/3	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	uptake [57] 21/25 39/18 47/11 47/13
treatment [3] 90/21 91/21 103/17	two weeks [1] 69/17	under-vaccinated [1] 186/18	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
treatments [1] 93/25	type [6] 21/15 122/23 170/18 171/4 191/17 193/22	under-vaccination [1] 186/17	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
tree [4] 149/1 149/2 149/2 175/13	types [2] 76/13 131/20	underestimate [1] 41/14	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
tremendous [1] 68/1	U	underlying [3] 86/23 143/17 189/1	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trends [1] 194/22	UK [49] 23/15 25/5 26/21 31/3 31/12 31/17 31/25 32/3 32/5 32/25 33/7 33/11 33/17 33/18 41/22 49/14 68/17 74/23 77/8 77/12 77/15 78/4 79/11 100/17 104/14 109/8 111/2 112/7 113/15 114/15 114/20 114/21 117/15 118/9 119/6 122/21 143/19 148/12 148/16 155/10 156/12 162/4 163/19	undermining [1] 138/23	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
triage [2] 206/1 206/20		underpinned [1] 8/6	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
triaging [1] 205/21		underpinning [1] 35/21	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trialled [1] 155/17		underserved [6] 176/24 177/24 192/23 195/17 198/11 198/21	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trials [2] 138/17 139/7		understand [18] 7/22 26/16 29/23 34/9 37/21 39/18 42/7 52/21 52/25 60/19 69/7 123/2 133/19 134/6 136/17 139/3 155/9 155/15	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
tribunal [1] 187/1		understandably [1] 34/22	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
tried [3] 91/16 118/1 135/17		understanding [11]	United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
Tropical [4] 143/15 144/10 144/19 144/25			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
troubleshooting [1] 90/14			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
true [4] 64/4 73/3 86/18 108/1			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trust [25] 53/22 53/23 86/25 87/1 87/10 121/22 122/9 123/22 125/12 126/7 126/13 126/19 138/10 157/24 167/11 172/24 178/4 178/17 179/9 189/3 195/19 195/23 195/23 197/4 199/6			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trust's [1] 124/16			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trust-based [2] 123/22 125/12			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	
trust-building [1] 195/19			United Kingdom [22] 15/14 22/23 22/25 24/16 24/20 28/4 28/15 56/3 123/25 130/13 132/21 143/24 145/12 147/12 150/24 151/9 157/3 165/12 172/8 191/4 191/24 199/25	

U	58/16 59/15 60/6 71/23 72/4 81/2 82/4 101/19 109/3 114/2 114/9 114/10 121/20 122/7 122/18 123/7 123/16 129/4 129/5 129/6 133/21 153/1 153/6 156/4 159/24 163/16 174/7 187/20 191/23 193/14 201/19 207/8 207/10 207/19 useful [3] 76/22 76/23 138/3 using [14] 22/20 23/10 30/1 35/4 52/18 54/19 72/13 93/10 106/14 123/22 124/16 126/4 156/8 175/10 usually [3] 73/5 199/19 201/25 utilise [2] 49/12 124/4 utilised [3] 125/12 173/15 175/3	159/9 159/14 170/23 171/6 171/8 171/10 172/2 172/8 vaccine [189] 5/9 5/10 5/20 9/5 9/7 10/16 11/2 11/10 11/12 12/22 14/8 14/18 15/15 16/3 16/6 16/10 16/10 16/12 16/22 17/14 17/17 18/16 19/23 21/8 21/15 23/6 23/16 23/17 24/1 24/15 24/18 29/15 30/21 30/22 31/12 31/17 32/1 33/1 36/25 38/2 38/12 38/21 42/17 44/3 44/19 46/6 46/7 46/18 46/20 46/23 50/20 50/21 51/9 51/17 56/10 58/3 58/4 58/11 58/15 58/19 58/21 59/17 60/9 60/12 60/24 62/21 64/15 64/16 64/17 64/18 66/1 67/11 67/24 68/7 68/16 68/18 68/24 69/4 69/16 69/21 70/20 72/19 72/21 74/8 75/22 77/9 79/18 79/22 80/3 80/19 81/1 81/18 84/4 84/8 84/12 87/4 87/5 87/6 87/7 87/24 88/9 88/19 90/16 92/7 92/19 93/6 93/18 95/25 97/9 101/9 101/21 103/11 103/23 104/2 104/10 105/2 105/4 105/16 106/9 110/6 110/20 112/23 117/15 119/7 119/20 119/21 119/22 121/25 122/9 122/24 123/13 123/15 124/5 124/9 124/23 127/4 128/2 128/12 128/15 128/16 128/21 129/19 130/2 130/3 130/7 132/13 132/15 137/20 137/22 138/17 138/18 143/6 143/17 144/20 146/10 147/8 148/17 149/22 149/23 150/9 161/21 162/14 164/11 167/1 168/11 168/22 172/20 176/3 176/11 179/11 182/21 183/1 183/17 184/2 186/7 187/6 192/15 192/16 198/14 199/14 199/16 199/20 201/7 201/9 201/14 203/8 204/7 205/2 207/9	vaccine's [2] 79/25 191/24 vaccine-related [1] 168/22 vaccines [82] 3/18 7/11 11/6 11/19 13/4 13/19 14/3 17/4 17/8 17/20 20/12 22/19 22/19 22/24 23/13 28/6 30/14 30/19 38/4 38/17 47/13 53/3 58/8 58/9 59/15 65/19 66/2 66/18 74/18 74/20 80/10 84/19 92/11 93/13 102/6 105/9 105/22 106/21 106/25 109/2 112/20 113/18 114/11 114/24 138/6 138/8 138/23 139/1 139/4 139/21 141/4 144/18 146/24 147/11 149/10 149/11 149/16 150/23 151/19 154/15 158/10 165/15 165/20 166/14 170/24 172/5 173/4 173/19 174/17 174/20 174/21 178/24 179/8 181/2 181/18 188/2 189/4 192/13 195/12 197/5 200/7 205/17 value [1] 183/20 variable [1] 80/5 variation [1] 162/16 varied [3] 11/21 17/6 187/7 variety [8] 97/10 114/2 122/8 126/19 127/18 129/17 198/5 199/7 various [9] 52/2 90/18 117/11 130/21 146/14 148/14 162/3 162/4 205/25 vary [1] 60/10 vast [2] 17/12 19/21 Vaughan [1] 36/20 Vaughan Gething [1] 36/20 vax [1] 98/25 VDPS [2] 100/14 140/7 venous [1] 103/18 verbal [1] 121/7 version [4] 48/17 57/10 77/11 77/20 versions [1] 194/6 versus [1] 126/8 very [176] 1/11 2/8 3/7 7/8 10/16 10/21 14/7 14/21 14/23 15/20 15/20 16/7 19/25 23/23 27/20 27/23 32/16 32/21	33/16 34/4 36/1 44/11 45/4 45/11 46/11 49/3 52/7 56/23 57/16 61/11 62/24 63/3 63/6 63/8 71/13 75/21 76/8 77/18 77/21 77/21 79/24 80/5 80/25 83/21 84/7 87/14 87/20 91/11 91/19 92/16 92/16 93/1 93/3 93/20 94/5 96/5 96/20 98/1 99/3 99/13 99/24 100/8 100/25 101/2 101/8 101/11 101/12 103/10 104/17 105/24 105/25 106/17 106/19 106/23 107/2 109/11 109/24 109/24 110/16 110/16 112/9 112/9 113/6 113/6 114/4 114/4 114/22 115/10 115/11 115/11 115/18 116/17 116/17 116/18 118/2 118/22 118/22 119/5 120/10 120/15 122/6 122/6 122/14 123/6 123/6 123/8 123/8 123/14 123/23 123/24 124/3 124/3 124/17 124/17 125/7 126/22 126/23 127/5 129/4 130/20 131/9 131/9 132/24 134/4 135/8 135/8 135/10 135/12 135/12 137/9 138/15 138/19 138/24 139/24 139/24 141/10 141/12 141/16 142/3 142/9 142/15 142/25 143/1 147/25 150/16 151/5 151/6 151/6 152/17 154/1 155/12 155/21 162/5 162/9 164/17 164/21 164/23 166/3 167/20 169/23 177/11 178/14 179/14 182/18 190/7 195/16 195/24 198/3 199/9 200/10 203/5 204/20 208/20 208/22 209/2 209/7 via [4] 166/14 167/6 167/22 179/9 video [1] 101/13 videos [2] 57/13 201/2 view [27] 46/20 67/20 73/10 78/5 84/3 86/23 87/7 102/2 113/20 114/4 115/8 118/17 119/12 119/14 123/12 125/23 127/4 136/21 146/2 146/8 149/24 155/2 173/13 194/9
----------	---	--	--	---

V	65/13 65/19 65/23 67/14 67/22 68/4 70/17 70/20 71/1 71/7 71/16 71/25 72/4 72/11 73/1 73/15 74/8 74/14 74/18 74/20 75/9 75/11 75/14 75/15 77/14 77/15 77/24 78/5 78/25 80/2 80/12 80/20 80/24 81/5 81/6 81/18 82/18 82/24 83/5 84/3 84/6 85/6 85/7 85/11 85/20 85/23 86/3 86/19 86/24 86/25 89/18 89/22 90/2 90/6 90/8 90/12 90/18 91/6 92/5 92/9 92/24 93/12 94/8 94/12 95/1 95/20 98/14 98/21 99/14 100/5 100/20 101/25 103/24 147/23 147/24 148/21 161/7 161/13 164/9 167/12 168/19 172/25 182/6 182/6 182/18 183/3 183/17 184/8 184/9 190/10 190/17 191/8 200/21 201/12	wastage [8] 11/7 14/11 16/11 28/7 44/3 58/19 58/22 83/25 waste [5] 11/10 58/2 68/16 84/4 174/11 way [45] 5/8 16/20 17/6 26/2 26/4 34/10 42/13 43/4 48/8 51/16 51/24 54/3 56/2 56/5 60/24 67/12 72/25 76/1 80/12 88/23 94/10 96/5 96/22 114/5 117/12 135/15 137/21 140/10 152/12 154/13 157/8 157/23 159/2 162/15 163/17 165/21 167/8 167/21 178/18 184/23 199/15 202/7 204/21 207/25 208/1 way to [1] 88/23 ways [5] 53/21 59/22 90/14 129/17 153/19 we [525] we'd [6] 6/1 14/23 15/3 19/18 39/18 47/4 we'll [11] 5/21 7/12 9/25 10/4 27/24 39/23 69/9 112/16 128/3 145/15 203/21 we're [22] 8/20 13/1 60/25 101/8 106/23 140/10 142/13 145/10 146/4 151/22 152/16 152/25 154/1 168/2 168/16 171/19 181/25 185/14 189/15 191/16 194/1 200/18 we've [25] 12/6 22/15 40/12 48/25 73/10 88/8 95/16 97/22 113/22 114/9 116/2 127/7 139/25 144/14 145/23 173/9 174/7 175/21 178/23 182/7 183/18 185/12 188/8 193/7 195/20 weather [2] 44/16 62/3 Weatherby [2] 204/18 204/20 Weaver [6] 137/12 137/13 137/16 137/19 141/10 210/16 webinars [1] 201/2 website [3] 37/12 90/8 120/17 week [6] 80/8 83/1 98/23 123/17 124/23 174/21 weekend [2] 83/1 92/23 weekly [3] 37/9 76/15 115/4	weeks [5] 36/23 69/17 84/1 124/4 127/17 welcome [1] 90/7 welcomed [3] 5/20 5/23 5/25 welcoming [1] 48/4 well [110] 2/14 3/15 5/12 10/16 12/6 16/12 18/4 18/20 21/4 27/4 28/1 37/4 38/10 38/12 44/15 49/2 51/5 52/14 53/9 54/19 57/7 61/2 62/6 63/8 66/21 70/9 71/17 74/9 77/6 80/13 82/10 82/17 83/21 83/21 86/17 92/16 94/6 103/6 104/15 106/4 106/11 106/17 108/24 109/20 110/2 110/2 110/4 110/7 110/17 110/19 111/7 111/19 112/21 113/1 113/5 114/24 115/7 115/10 116/18 116/20 116/21 118/14 119/22 120/17 121/1 121/10 122/13 122/14 122/17 125/18 130/4 130/16 130/25 132/1 132/22 134/4 134/23 137/22 139/21 140/9 141/16 148/13 149/2 150/21 151/7 153/8 153/15 155/15 160/14 162/11 165/23 166/13 172/10 172/11 181/10 188/15 189/6 193/24 194/10 194/12 194/20 196/7 197/14 200/17 202/21 203/1 203/23 206/4 206/9 209/7 well trusted [1] 110/17 well-developed [1] 193/24 Welsh [21] 25/10 64/12 65/9 66/19 67/11 72/3 73/11 73/17 77/25 80/17 82/15 82/18 84/11 87/20 90/13 96/12 96/15 97/6 100/22 182/10 182/10 went [14] 18/1 19/18 20/1 23/20 41/10 55/9 73/15 78/6 104/12 109/5 119/4 125/14 132/2 136/10 were [395] weren't [12] 2/6 10/12 12/16 24/13 26/24 37/23 61/5 118/25 119/18 124/8	141/23 154/2 Westminster [2] 28/21 31/16 what [147] 1/21 2/13 5/9 5/16 5/21 8/8 8/9 10/10 10/11 11/13 12/13 13/25 14/10 14/12 16/15 17/18 18/25 19/9 20/21 21/24 24/3 24/18 27/7 29/7 29/12 32/4 34/9 36/7 37/17 38/16 39/1 47/19 47/21 48/15 51/4 52/21 52/21 52/25 53/1 56/21 57/1 59/14 60/2 61/24 62/9 63/3 65/24 68/12 71/18 72/14 72/15 73/18 74/25 75/3 75/25 79/23 80/19 80/20 83/15 85/1 86/1 86/23 87/14 88/7 92/10 93/11 93/14 94/18 95/2 97/7 102/2 103/3 103/21 103/24 109/18 110/13 110/22 111/10 111/19 112/17 112/19 113/20 114/16 114/23 118/3 118/7 118/25 119/5 119/7 120/1 120/2 120/7 120/10 120/15 120/16 121/6 122/25 123/21 124/12 126/2 128/1 128/17 131/10 131/17 132/3 132/11 132/11 132/12 135/16 139/1 139/11 139/16 145/8 145/24 145/25 145/25 146/2 146/11 150/22 151/1 152/15 155/16 155/16 155/23 156/12 158/20 160/7 160/12 166/10 170/4 173/13 175/11 176/18 176/19 176/25 180/1 180/16 181/13 185/12 191/15 192/2 198/17 199/14 200/3 205/16 206/4 206/6 what's [9] 22/20 143/17 144/13 146/14 162/20 176/10 177/5 177/11 177/11 whatever [3] 54/20 80/13 193/22 WhatsApp [6] 76/19 76/23 77/4 115/5 118/5 118/23 WhatsApps [2] 27/25 32/16 when [54] 2/6 2/7 2/12 3/17 16/17 17/20 20/25 23/22 25/21
W	65/13 65/19 65/23 67/14 67/22 68/4 70/17 70/20 71/1 71/7 71/16 71/25 72/4 72/11 73/1 73/15 74/8 74/14 74/18 74/20 75/9 75/11 75/14 75/15 77/14 77/15 77/24 78/5 78/25 80/2 80/12 80/20 80/24 81/5 81/6 81/18 82/18 82/24 83/5 84/3 84/6 85/6 85/7 85/11 85/20 85/23 86/3 86/19 86/24 86/25 89/18 89/22 90/2 90/6 90/8 90/12 90/18 91/6 92/5 92/9 92/24 93/12 94/8 94/12 95/1 95/20 98/14 98/21 99/14 100/5 100/20 101/25 103/24 147/23 147/24 148/21 161/7 161/13 164/9 167/12 168/19 172/25 182/6 182/6 182/18 183/3 183/17 184/8 184/9 190/10 190/17 191/8 200/21 201/12 Wales' [1] 67/24 walk [1] 174/3 walk-ins [1] 174/3 want [28] 12/25 18/18 21/14 56/3 74/17 89/10 92/4 117/25 121/11 131/10 133/17 146/7 149/18 152/15 166/25 167/15 168/2 168/5 168/20 177/9 178/13 185/5 188/7 196/24 199/21 202/12 203/17 205/1 wanted [9] 32/9 56/16 110/1 110/2 112/8 118/6 118/25 157/12 168/11 wanting [2] 28/7 189/15 warehouse [1] 30/22 warned [1] 160/22 was [629] was like [1] 21/25 was one [1] 164/25 was to [1] 69/22 wasn't [30] 5/19 5/22 5/25 14/3 15/22 16/24 19/25 20/3 20/24 25/1 25/8 26/21 30/16 50/16 53/20 54/25 55/19 59/16 68/21 91/2 113/11 117/18 120/21 136/8 152/1 155/19 158/4 164/16 174/9 193/23	Wagner [4] 204/21 204/22 206/23 210/22 wait [4] 37/20 59/12 104/10 104/15 waiting [2] 63/19 69/5 Wales [103] 25/8 27/3 34/6 36/20 64/12 64/15 64/16 65/4 65/6		

<p>W</p> <p>when... [45] 28/14 28/17 29/18 30/6 30/22 35/18 39/8 39/18 42/18 43/13 43/25 55/22 56/25 57/9 58/15 69/19 71/5 86/5 89/20 92/5 92/19 94/9 94/14 99/20 99/21 103/1 116/22 121/2 125/6 129/1 129/12 130/6 132/8 134/8 137/14 148/19 162/7 177/21 182/20 182/21 183/11 189/25 198/11 199/12 202/15</p> <p>where [59] 6/2 6/4 7/4 18/10 23/11 23/23 24/10 26/3 26/14 26/23 28/25 31/8 33/5 34/14 36/8 43/16 45/14 46/5 47/17 60/9 60/18 66/11 72/5 75/21 79/8 80/9 81/1 96/13 102/6 103/14 104/5 115/12 123/22 125/8 125/16 125/23 149/3 153/3 154/17 154/23 155/12 158/15 168/4 168/10 171/20 174/1 175/15 175/22 178/25 181/14 182/4 193/5 193/16 195/24 199/2 201/15 201/20 202/2 207/24</p> <p>whereas [4] 75/10 165/23 182/24 192/10</p> <p>whereby [3] 32/12 37/9 178/16</p> <p>wherever [2] 11/10 58/3</p> <p>whether [31] 4/23 26/17 33/11 33/12 33/14 49/11 55/8 94/18 95/5 102/5 109/1 113/20 119/24 120/5 120/7 131/16 131/22 147/21 149/8 149/14 157/4 162/19 165/9 166/10 168/5 170/11 172/6 173/14 174/6 193/10 196/24</p> <p>whether Northern [1] 131/16</p> <p>which [172] 2/24 3/4 6/14 7/6 7/14 7/17 7/22 9/4 9/13 11/11 11/16 11/17 11/19 11/23 12/25 13/3 17/12 18/5 22/9 22/21 22/21 24/13 25/4 25/6 25/24 25/25 26/5 28/18 28/21 29/4</p>	<p>29/19 30/13 30/14 31/16 32/20 33/10 33/15 33/24 34/10 38/22 40/15 41/21 41/22 43/22 48/1 48/16 49/11 51/5 53/3 56/1 56/4 56/4 57/8 58/4 58/9 61/10 61/23 65/23 68/4 70/12 71/8 71/24 72/20 72/22 73/18 76/25 77/21 78/23 79/1 83/2 83/7 87/9 87/21 93/1 93/9 94/4 94/8 98/14 99/2 100/11 100/16 101/2 101/9 101/19 111/17 113/1 113/14 113/16 113/24 114/2 115/24 116/4 116/14 118/4 121/3 121/9 121/12 123/15 127/5 127/12 127/19 127/20 128/14 128/23 129/9 129/10 129/14 129/14 129/24 134/9 134/15 136/7 138/8 138/16 143/7 144/14 144/20 144/21 146/5 146/9 148/5 149/9 149/10 149/24 150/9 152/12 153/12 154/4 154/9 155/6 156/3 156/5 157/1 157/9 159/24 161/17 164/10 165/3 166/1 167/5 167/22 168/19 169/14 170/22 170/25 172/5 172/20 173/22 174/23 175/2 175/20 178/15 178/18 179/5 179/13 181/18 182/13 183/18 187/21 190/9 192/4 192/13 193/13 193/14 195/3 195/4 198/25 202/2 204/2 204/4 207/6 208/5</p> <p>while [2] 37/18 138/12</p> <p>whilst [8] 29/9 42/5 59/8 61/7 71/2 133/10 134/1 159/12</p> <p>white [5] 57/5 86/6 187/6 187/12 200/2</p> <p>who [102] 2/22 3/20 10/19 13/10 13/22 13/22 16/21 20/13 23/6 27/15 27/15 39/8 39/10 40/2 40/2 40/5 40/9 41/17 42/9 45/20 45/20 47/5 49/4 49/7 49/20 49/23 50/2 55/10 55/17 57/3 59/11 60/1 60/15 64/18 72/3 73/15 85/13 85/14 86/2 86/3</p>	<p>88/13 91/7 91/19 93/12 95/10 96/4 98/2 99/18 102/5 103/11 103/22 110/8 111/14 116/8 116/14 126/6 126/8 127/15 130/1 134/5 136/4 137/19 137/22 137/23 158/17 159/14 161/20 161/23 161/25 163/3 163/5 163/6 163/11 164/18 166/16 170/6 171/10 171/15 171/16 176/6 176/7 176/15 185/17 187/9 187/15 188/21 189/11 191/13 193/8 193/9 193/18 193/19 198/15 199/21 204/21 204/21 205/8 205/20 207/22 208/9 208/17 209/2</p> <p>who'd [1] 161/11</p> <p>who's [2] 129/13 164/22</p> <p>whole [16] 14/6 14/7 17/23 19/1 44/1 49/20 52/24 75/2 83/1 83/4 87/8 131/22 157/3 158/8 183/6 185/21</p> <p>whom [5] 59/12 69/6 93/5 142/13 193/23</p> <p>why [23] 5/22 10/12 13/13 16/4 20/3 20/23 21/2 37/21 70/23 98/21 100/5 133/19 133/20 135/15 138/7 156/6 160/2 176/9 191/16 196/4 197/19 197/19 202/20</p> <p>Wick [1] 30/22</p> <p>wide [5] 32/3 33/7 77/8 119/6 194/13</p> <p>widely [2] 114/10 184/15</p> <p>wider [7] 5/13 27/13 118/9 120/9 121/5 165/13 165/13</p> <p>Wilcock [6] 132/25 132/25 133/1 136/14 137/10 210/15</p> <p>will [26] 8/19 15/7 22/6 22/7 39/3 57/21 61/23 72/16 76/5 87/9 91/13 91/25 96/4 135/6 145/17 158/8 160/16 179/5 184/9 187/23 195/18 197/23 202/2 204/10 204/23 208/23</p> <p>Windrush [1] 195/22</p> <p>winter [6] 5/5 17/19 44/17 62/3 161/12 179/19</p> <p>wish [3] 22/10 26/25</p>	<p>64/8</p> <p>wished [1] 43/4</p> <p>withdrew [4] 63/7 107/5 142/11 209/6</p> <p>within [45] 2/16 2/17 2/24 3/22 4/15 4/18 6/9 7/14 7/18 11/16 12/22 14/7 14/9 15/24 19/12 20/8 26/8 39/23 41/6 41/6 45/10 52/16 52/23 55/17 61/14 67/13 85/21 89/11 105/22 112/4 112/11 115/23 124/2 124/5 124/6 126/19 129/21 151/9 152/2 153/23 157/15 171/15 179/15 183/12 195/24</p> <p>without [5] 11/7 86/11 104/22 127/3 138/22</p> <p>witness [13] 1/4 1/12 63/7 63/14 63/16 63/24 107/5 107/11 107/12 107/21 142/11 167/18 195/2</p> <p>witnesses [3] 141/24 145/24 209/6</p> <p>women [1] 158/17</p> <p>won't [3] 88/24 160/16 196/10</p> <p>wondering [1] 131/16</p> <p>word [5] 14/15 70/19 183/9 197/20 202/24</p> <p>words [3] 5/19 51/14 64/8</p> <p>work [47] 2/5 5/14 18/24 19/21 21/6 22/11 23/2 33/19 35/11 35/19 47/8 48/18 52/23 53/13 65/15 68/21 69/25 70/8 79/11 84/11 86/13 88/10 88/18 90/4 99/19 100/13 101/6 106/12 111/16 115/12 117/25 132/9 132/16 140/19 145/7 149/17 154/6 156/22 169/24 172/12 184/15 194/3 194/9 198/23 201/13 202/2 209/1</p> <p>worked [34] 3/7 16/20 24/14 27/20 28/1 53/18 64/22 66/23 70/9 82/25 92/16 93/3 93/14 93/17 93/20 94/16 101/2 109/21 110/9 110/12 111/6 115/20 116/21 117/12 119/22 122/5 124/1 130/23 131/3 135/4 151/11</p>	<p>172/9 172/11 181/9</p> <p>worker [2] 164/19 191/13</p> <p>workers [17] 16/8 44/13 49/13 50/5 66/9 99/4 99/18 100/6 100/9 133/25 135/7 135/24 159/15 159/17 164/9 164/10 172/1</p> <p>workforce [16] 7/1 12/22 18/1 19/4 28/8 40/22 44/20 49/11 64/17 70/1 117/4 146/24 147/1 170/20 189/8 189/11</p> <p>workforce-related [1] 146/24</p> <p>workforces [2] 99/24 99/25</p> <p>working [23] 18/20 19/2 19/19 28/10 35/17 38/7 53/1 70/25 88/22 92/12 96/18 99/7 115/17 125/3 129/20 130/13 135/21 136/4 137/8 151/5 165/2 199/3 202/22</p> <p>workings [1] 70/17</p> <p>workplaces [1] 17/4</p> <p>works [4] 60/16 102/7 154/15 156/4</p> <p>workstreams [2] 68/17 68/22</p> <p>World [1] 90/4</p> <p>worried [2] 91/8 94/7</p> <p>worrying [1] 93/7</p> <p>would [140] 5/16 14/19 15/4 17/13 19/19 19/23 20/18 22/10 22/20 22/23 22/25 23/9 23/14 24/5 24/17 28/1 28/2 29/3 29/3 29/4 30/6 31/4 32/10 38/12 38/17 39/9 41/9 41/9 44/13 44/21 44/24 48/4 51/4 51/9 52/12 52/20 52/25 53/5 53/21 60/10 60/24 62/11 65/22 65/23 66/3 69/14 72/8 72/8 73/24 73/24 74/5 75/17 76/9 78/4 78/5 78/8 78/11 78/23 80/10 81/10 84/11 84/21 84/21 88/2 89/12 90/6 93/15 93/19 94/1 95/8 96/14 97/16 97/24 99/22 99/23 100/9 102/16 103/15 103/19 109/13 110/6 110/25 112/2 112/3 113/18 117/7 118/17 120/1 120/14 120/22 123/11 124/21</p>
--	--	--	--	--

W
would... [48] 127/8
 128/5 128/7 128/8
 130/6 130/8 131/24
 132/20 134/18 136/21
 138/6 147/15 150/11
 150/15 152/7 152/25
 156/17 156/18 157/5
 159/1 159/6 159/9
 159/15 161/25 163/22
 163/23 164/10 164/20
 166/25 169/8 171/10
 174/14 174/16 176/14
 176/18 179/12 180/10
 180/17 181/5 184/16
 189/4 189/22 198/3
 199/5 203/10 204/13
 206/1 206/18
wouldn't [10] 23/4
 46/21 60/4 67/23 89/2
 91/4 91/8 127/3 169/6
 193/19
write [3] 36/19 69/14
 138/2
writes [1] 25/25
writing [1] 149/20
written [3] 85/12
 85/12 121/9
wrong [6] 21/15 27/5
 27/7 33/24 59/16
 184/1
wrote [3] 31/15 100/2
 173/11

Y
yeah [43] 1/10 9/9
 9/16 17/7 21/20 34/13
 37/11 45/19 45/23
 48/12 49/6 49/9 54/11
 56/11 56/20 56/22
 65/14 69/23 121/15
 138/24 146/13 147/15
 147/24 151/15 152/15
 158/14 161/23 168/2
 169/20 171/7 174/14
 174/18 175/11 177/6
 183/9 184/16 186/8
 188/24 192/6 193/6
 193/13 206/19 206/21
year [13] 13/9 14/17
 14/25 15/3 26/18 46/8
 47/14 47/20 75/9
 126/16 188/16 188/20
 188/22
years [10] 7/19 7/25
 18/12 73/16 75/13
 92/13 97/22 143/22
 143/23 188/6
Yellow [5] 101/23
 102/12 139/10 140/6
 140/9
yes [166] 2/4 2/16
 3/16 4/11 4/21 6/12

6/21 7/2 9/20 9/23
 9/25 15/22 17/15
 17/17 22/12 22/14
 24/3 24/23 27/9 27/22
 28/9 28/23 30/17
 32/14 35/10 40/18
 41/19 42/9 43/5 50/6
 50/25 52/6 53/15 62/6
 65/12 67/8 67/9 68/11
 70/7 70/22 70/25
 71/21 72/18 74/1
 74/11 74/15 74/22
 75/2 76/18 76/21
 76/24 77/2 78/7 78/24
 79/2 79/24 80/16 81/8
 81/22 82/5 82/9 82/19
 83/8 84/5 85/9 85/12
 85/17 86/16 87/25
 88/2 88/12 88/19 89/7
 89/14 89/17 90/23
 91/5 93/8 94/11 94/17
 95/3 95/3 95/15 95/19
 95/22 97/3 98/13
 98/17 98/23 100/15
 100/21 101/24 104/1
 107/18 108/2 108/2
 108/6 108/12 108/20
 108/24 110/15 111/13
 112/21 113/22 115/25
 116/24 116/24 117/3
 117/5 117/5 117/7
 118/8 119/13 121/1
 122/3 123/1 125/10
 126/4 127/7 128/1
 128/11 128/20 130/5
 131/15 131/18 140/9
 140/17 140/17 141/15
 141/19 141/25 142/3
 143/12 144/17 146/16
 147/3 150/20 152/7
 157/18 160/21 164/4
 167/14 169/6 171/5
 179/16 181/3 181/5
 183/21 183/24 184/7
 184/10 185/2 185/20
 186/20 188/3 190/14
 190/18 190/25 191/7
 195/14 198/17 200/1
 200/1 200/5 200/15
 207/1
yet [2] 66/6 78/3
you [635]
you'd [3] 16/20 38/7
 192/24
you'll [5] 133/11
 134/14 166/1 184/1
 203/23
you're [25] 8/1 16/9
 17/20 22/14 25/13
 26/6 42/11 49/19
 59/14 61/11 88/5
 114/23 121/2 121/6
 128/19 130/6 146/22
 154/8 154/19 154/23

164/21 195/5 196/8
 198/22 208/10
you've [40] 9/13
 13/13 13/22 16/1
 18/19 27/4 27/7 27/20
 30/1 40/23 51/10
 54/23 55/25 56/9
 59/22 65/2 67/12
 67/15 72/25 95/1
 104/25 105/21 120/23
 131/19 141/20 143/22
 143/23 147/2 149/3
 151/3 166/15 183/14
 185/15 188/14 191/25
 203/7 204/5 204/10
 205/25 207/7
young [7] 76/8
 161/13 165/8 165/14
 165/20 166/7 166/11
younger [5] 44/22
 46/5 114/21 186/14
 186/19
your [119] 1/8 1/9
 1/12 1/18 3/3 4/5 4/18
 5/18 5/19 6/9 6/10 7/3
 16/20 24/15 25/3
 27/21 32/17 35/11
 35/14 41/6 55/24
 57/19 57/25 59/23
 62/2 62/25 63/4 63/21
 64/1 64/7 64/9 64/21
 65/8 65/15 66/16
 66/25 67/4 67/10
 67/20 67/20 68/18
 68/21 73/10 74/25
 77/11 78/5 84/2 84/3
 86/23 91/21 94/12
 100/17 101/20 102/2
 105/7 105/8 106/20
 107/2 107/3 107/17
 107/23 108/3 108/15
 109/18 113/20 115/8
 115/23 117/17 117/19
 121/13 126/1 126/3
 127/4 136/2 137/14
 138/1 141/17 142/9
 142/20 142/21 143/1
 143/5 143/16 144/8
 144/24 145/7 146/9
 146/18 150/5 154/18
 154/18 165/10 167/4
 168/17 172/6 175/6
 184/11 189/24 194/9
 195/4 197/11 197/20
 200/20 202/20 202/24
 203/12 203/22 204/1
 205/3 205/15 205/16
 207/5 207/12 208/12
 208/22 208/22 208/24
 209/1 209/3
yourself [2] 32/16
 87/13
Yousaf [1] 3/12

Z
zoom [1] 117/21