

UK COVID-19 PUBLIC INQUIRY

Fifth Witness Statement of Professor Philip Banfield

I, Professor Philip Banfield, of the British Medical Association (the BMA or the Association), will say as follows:

1. I am the chair of the BMA's UK council, chair of the BMA's board of directors and a member of the chief officer team of the BMA. I am a Consultant Obstetrician and Gynaecologist based in North Wales and an honorary professor in the Cardiff University School of Medicine. Before being appointed as chair of council, I spent several years as a representative of BMA Cymru Wales, as chair of both Welsh council and the Welsh consultants committee. I have sat on the UK council since 2012.
2. I provide this statement in response to a request for evidence made on 14 December 2023 by the UK COVID-19 Public Inquiry (the Inquiry) under Rule 9 of the Inquiry Rules 2006 in connection with Module 4 of the Inquiry.
3. I provided four previous witness statements to the Inquiry in connection with Module 1 of the Inquiry dated 12 April 2023, Modules 2 (including submodules 2A, 2B and 2C) of the Inquiry dated 21 July 2023, Module 2B of the Inquiry dated 01 February 2024, and Module 3 of the Inquiry dated 03 May 2024.
4. I took on the role of chair of UK council of the BMA in July 2022, after the period identified by the Inquiry as having particular relevance to the Rule 9 request (namely, 1 March 2020 to 28 June 2022). During the relevant period covered by this Rule 9 Request I was Chair of BMA Welsh Consultants Committee and a member of UK Council.
5. In providing this corporate statement to the Inquiry, I have sought input and assistance from colleagues in BMA Northern Ireland, BMA Scotland and BMA Cymru Wales, as well as from relevant UK policy and communications teams across the Association.

The information contained within this statement is true to the best of my knowledge and belief.

A. Introduction and overview of key messages

6. The BMA views the COVID-19 vaccination programme as one of the biggest successes of the pandemic response. This is in large part due to the efforts of healthcare workers, particularly GPs and their practice teams.
7. The unprecedented scale of the vaccination programme saved millions of lives globally. A study by the World Health Organization (WHO) found that countries who implemented vaccination programmes early – such as the UK – saw the greatest benefit in terms of number of lives saved overall through vaccination. In the UK, it is estimated that COVID-19 vaccination reduced mortality by 70% in adults aged 25 and over (PB/671 - INQ000472218).
8. However, the UK's vaccination effort was not without its challenges. Insufficient consideration was given to workforce planning which led to many healthcare workers, including GPs and practice staff, having to work additional hours to meet the Government's vaccination targets, alongside continuing to deliver non-COVID and COVID-19 care. These combined pressures resulted in medical professionals reporting stress, burnout and fatigue.
9. In England, the issue was further compounded by slow and inefficient payment for the extra work conducted by GP practices which was essential to maintain operations and deliver vaccines. The BMA repeatedly called on NHS England (NHSE) to free-up GP time from needless bureaucracy (e.g. Quality Outcomes Framework) and low-priority undeliverable targets. Many practices did not have the staff, capacity, or time to deliver the vaccination programme at scale, because of other work that they were contractually bound to by NHSE. The BMA made it very clear that GPs and their teams would do all they could, as they did throughout the pandemic.
10. Issues with vaccine uptake emerged across the four nations. Prior to the COVID-19 vaccination programme, it was known via studies on vaccination intention and learning from other vaccination programmes that there may be lower rates of uptake of the vaccine among some population groups, including some ethnic minority groups and

those from deprived areas. When this became clear in early vaccination uptake data, efforts were made by Government, health and care systems and community leaders to overcome barriers to vaccine uptake which were welcome. However, significant disparities remain to this day, with root causes of vaccine hesitancy such as systematic racism still unaddressed.

B. Overview of the BMA, its members, and its role

11. The BMA is a professional association and trade union for doctors and medical students in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population, providing members with individual services and support throughout their lives.
12. As a trade union, the BMA is formally recognised for collective bargaining purposes at a UK, national and local level. It represents, supports, and negotiates on behalf of all doctors and medical students in the UK and has a membership of just over 196,000 (over half of practising) doctors.
13. Members of the BMA come from all branches of medical practice and specialties, for example GPs, consultants, public health, occupational medicine, medical academics, students and doctors in training.
14. The BMA's mission statement is 'We look after doctors so they can look after you'. Its vision is 'a profession of valued doctors delivering the highest quality health services, where all doctors:
 - a. Have strong representation and expert guidance whenever they need it.
 - b. Have their individual needs responded to, through career-long support and professional development.
 - c. Are championed by the BMA and their voices are sought, heard, and acted upon.
 - d. Can connect with each other as a professional community.
 - e. Can influence the advancement of health and the profession.

15. Staff and elected members work to support, protect, and represent BMA members across all four UK nations. This includes:

- a. Negotiating on pay, terms and conditions at a UK, national and local level, and supporting the safeguarding of health, safety, and wellbeing at work.
- b. Providing employment support and advice for members.
- c. Providing wellbeing support services, with a free confidential counselling line and peer support service available to all doctors and medical students.
- d. Providing other services for members, including advice related to immigration, ethics, equality and diversity, and specialist HR and employment law advice for GP partners.
- e. Ensuring doctors' voices are heard by policymakers across the UK's governments and healthcare systems. To do this the BMA conducts research, produces policy recommendations, runs campaigns and makes representations to governments and decision makers. The BMA also works with a range of European partners and makes representations at a global level as part of the World Medical Association.

Senior elected leadership

16. The Association's senior elected leadership is comprised of four chief officers. These are:

- a. The chair of council, who chairs the UK council and the BMA's board. The chair provides strategic leadership in developing and implementing BMA policies and represents the views of all BMA members externally.
- b. The deputy chair of council deputises for the chair of council both internally and externally. The deputy chair leads on issues and strategic projects as delegated by the chair of council and sits on the BMA board.
- c. The chair of the representative body is responsible for chairing and the smooth running of the Annual Representative Meeting (ARM) and

ensuring that the policy set by the ARM is acted on by the Association. The chair of the representative body sits on the BMA board and the BMA council, and leads the Association's policy work in particular areas, including workforce and climate change.

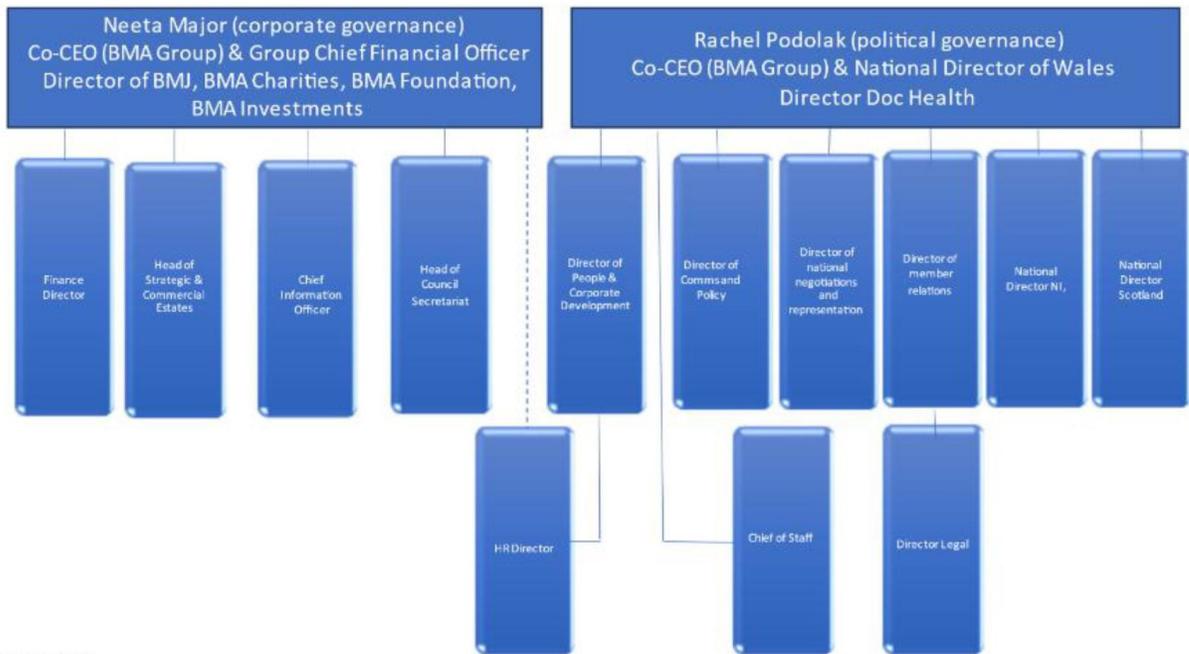
- d. The treasurer is responsible for the good stewardship of the Association's financial and property assets, and chairs key governance committees including the finance committee. The treasurer is a member of the BMA council and is deputy chair of the BMA board.

17. The BMA also appoints a President to serve a one-year term of office, commencing at the completion of the BMA's ARM held in June or July each year. The President undertakes work within and through the BMA on areas of interest and often represents the BMA at events or acts as a media spokesperson on these issues. Past Presidents have undertaken projects focused on health inequalities, children's health and the economic value of health. The President's role is largely ceremonial, and they do not play a role in the day-to-day running of the Association, although they are invited to sit, ex officio, as a non-voting member on all committees, including the UK council (with the exception of the organisation committee).

Senior staff leadership team

18. The BMA's senior staff leadership team works closely with the Association's chief officers and elected members. The co-chief executives lead the senior leadership team and BMA staff in the day-to-day running of the BMA. This involves the provision of services to members, such as employment advice, alongside delivering on the policies and priorities of BMA members, committees and their elected members in the BMA's role as a professional association and a trade union. The senior leadership team structure is set out below:

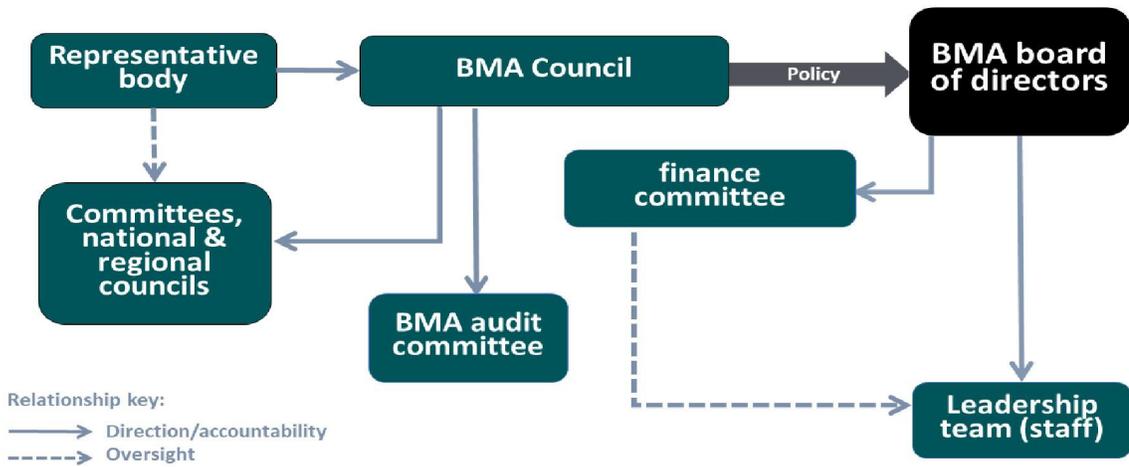
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Governance

19. The BMA's elected representational structure involves several local, regional and national forums. The relationship between the different governance bodies of the BMA is illustrated by the following diagram:



20. The following bodies operate at a UK-wide level:

- a. **The representative body:** This is the main policy-making function for the BMA, meeting once a year at the ARM (Annual Representative Meeting). Members of the representative body are elected by their peers, doctors and medical students from constituent bodies including divisions and branches of practice.
- b. **BMA UK council:** As the Association's principal executive committee, the UK council is responsible for the lawful conduct of the Association as a trade union and as a professional association. UK council sets the strategic direction of the Association (with the board) and co-ordinates the implementation of policy decided by the representative body at the ARM. It has the power to formulate and implement policies in between meetings of the representative body.
- c. **Board of directors:** The board is responsible for the management of the finances, operational administration, and strategic direction (with the UK council) of the BMA, in addition to oversight of the British Medical Journal (BMJ) (which is wholly owned by the BMA). The composition of the board of directors is outlined in the Articles of Association and By-laws of the BMA and includes:
 - i. the council chair (chair of the board);
 - ii. the representative body chair;
 - iii. the treasurer (deputy chair of the board);
 - iv. the deputy chair of council;
 - v. three medical persons as may be elected and/or replaced by council from time to time;
 - vi. the chief executive officer(s);
 - vii. the group chief finance officer;
 - viii. one lay (non-medical) person experienced in business and commerce to be elected and/or replaced by council from time to time;

ix. the BMJ chair.

Currently, the council has also appointed an additional lay (non-medical) person to the Board.

- d. **Branch of practice committees:** Reporting to the UK council, there are 12 UK branch of practice committees that represent doctors in different areas of medical practice, for example, GPs, consultants, resident doctors and public health. Branch of practice committees have delegated authority to negotiate terms and conditions of service.
- e. **Professional activities and special interest committees:** Reporting to the UK council, the professional activities and special interest committees represent the interests of doctors and patients across a range of professional activities and special interests. There are currently 11 UK professional activity and special interest committees.

21. At the devolved level, the following bodies operate:

- a. **Northern Ireland council, Scottish council and Welsh council:** reporting to the UK council, the national councils consider all matters of specific relevance to the medical profession and healthcare in their nations. They determine policy and action where the application is exclusive to their nation. The BMA's national offices have their own elected branch of practice structure and executive-led teams to enact policies set at the ARM that are relevant to their respective countries. Branch of practice committees have delegated authority to negotiate terms and conditions of service.
- b. **English Regional councils:** these are forums to discuss matters of regional interest, and report into the UK council. Regional councils do not have devolved authority.

22. The following structures also operate at a local level throughout the UK:

- a. **BMA divisions:** Every UK BMA member belongs to one of 180 divisions, which bring together members in all disciplines and branches of practice in their local area.

- b. **Local negotiating committees and forums:** Each trust and health board has a local negotiating committee that has the authority to make collective agreements with local management on behalf of medical and dental staff of all grades.
- c. **Local Medical Committees:** LMCs are local representative committees of NHS GPs in all four UK nations. While they are not part of the BMA structure, LMCs interact and work with – and through – the GPC (general practitioners committee) as well as other branch of practice committees and local specialist medical committees in a variety of ways, including conferences, and in providing guidance for practices.

C. BMA members' pre-pandemic roles and services provided

23. BMA members provide specialist and general medical services across NHS/HSC and other healthcare settings (including in the private sector).
- a. Doctors may be directly employed or contracted to work as locums. This is true in both general practice and in secondary care and across grades of doctors.
 - b. Independent contractor doctors work as self-employed partners in GP practices which are contracted by the NHS/HSC to deliver general medical services in all four UK nations. GP partners are also responsible for the day-to-day business operations related to running the practice (unlike employed doctors/salaried GPs).
 - c. Resident doctors in Foundation Programme, core training or specialty training will work under the supervision of senior doctors on a rotational basis in general practices and secondary care settings.
 - d. Medical students will undertake clinical placements as part of their undergraduate medical degree programme. These placements can take place in primary, secondary, community or other health and social care settings.

- e. BMA members may also be employed by local or national public health authorities, for example, in the case of public health doctors, or in academia or research organisations, in the case of medical academic staff.
- f. BMA members also work in private practice for independent sector organisations. For the majority of these doctors (usually consultants, as medical training is provided almost exclusively by the NHS), this work is often taken up on top of NHS work. However, there are some doctors who work exclusively in private practice.

Pre-pandemic vaccinations and immunisations

24. Prior to the pandemic, GP practices in England, Wales and Northern Ireland provided the following vaccinations and immunisations:

- a. Seasonal influenza.
- b. HPV (human papillomavirus).
- c. Shingles.
- d. Routine childhood vaccinations (diphtheria, tetanus, pertussis, polio, haemophilus influenza type b (hib) and hepatitis B, meningococcal group b (MenB), rotavirus gastroenteritis, meningococcal group c (MenC), pneumococcal, measles, mumps and rubella).
- e. Adult routine immunisations (Pneumococcal (23 serotypes).
- f. Selective immunisations (babies born to hepatitis B infected mothers, pertussis).
- g. Other vaccination programmes (meningococcal groups A, C, W and Y disease (completing dose), HPV (human papillomavirus) types 16 and 18 (and genital warts caused by types 6 and 11) (completing dose), and MMR 16 years and over).
- h. Travel vaccinations.

25. In Scotland, vaccinations were transferred out of the GP contract in 2018 to health boards. Prior to this, the vaccinations and the immunisations outlined above were provided by GPs.

D. BMA members' role, function and responsibilities in respect of COVID-19 vaccination programmes

COVID-19 vaccine delivery and rollout

26. All four nations took a mixed-delivery approach, using a large network of vaccination sites including hospital hubs, GP surgeries, pharmacies, and mass vaccination centres. The rollout was delivered with staff and volunteers working many additional hours to deliver the programme alongside a range of other demands (see paragraphs 70-72). To increase capacity to be able to deliver what was a huge vaccination programme, legislation was passed in England to allow a wider range of individuals to give vaccinations and by recruiting clinical and non-clinical paid staff and volunteers.¹

27. General practice had a key role to play in the successful rollout of the vaccination programme and delivered a large portion of the vaccines alongside COVID and non-COVID care. For example, in England, while there was a late suspension of some contractual targets, the day-to-day work of general practice continued as normal. By the end of October 2021, 71% of vaccines in England had been administered by GPs and their teams and community pharmacies, compared with 21% by vaccination centres and the remaining 8% in hospitals or other settings. This was also done at a significantly lower cost than in vaccination centres (PB/533 **INQ000065228**).

28. By the end of 2021, retired doctors wishing to return to service in England were also being encouraged to volunteer to help with the vaccination effort, whether administering jabs or assisting in consenting patients for vaccination. This followed advice from NHSE in an email communication to a BMA staff member (PB/400 –

¹ The National Health Service (Performers Lists, Coronavirus) (England) Amendment Regulations 2021

INQ000400471) and communicated to retired members in an email from the chair of the BMA Retired Members Committee.

29. As of Spring 2024, 47% of vaccines in Northern Ireland had been delivered by GP practices, 43% delivered by health and social care trusts, and 10% delivered by the pharmacy sector (PB/674 - INQ000479140).
30. In Wales, health boards were formally responsible for delivery of the COVID-19 vaccination programme. Welsh Government official data from 20 April 2021, showed that all of the 392 active practices in Wales were delivering COVID-19 vaccinations under a Primary Care Contracted Services: Immunisations specification from their local health board. Although approaches varied by health board, GP practices were usually vaccinating priority groups 1-5; with the rollout to other groups being undertaken at health board operated Mass Vaccination Centres. By July 2021, COVID vaccinations were only being delivered at 51 GP practices according to Welsh Government data, reflecting the fact that by that time most of the population had received their vaccination (PB/669 - INQ000479135).
31. In Scotland, vaccinations were the responsibility of health boards. The BMA Scotland GP committee agreed in November 2020 that GPs would not be the default delivery channel for vaccinations due to the need to maintain good IPC measures and appropriate physical distancing measures which would be constrained by the capacity of general practice. Health boards were to determine how many vaccinations are sought from their GP practices by reference to their local needs, consulting their Local Medical Committees (LMCs) and GP Sub-committees as appropriate. This was outlined in the COVID-19 Vaccination Directed Enhanced Service/NHS Circular 26 November 2020 (PB/685 - INQ000480991). Health boards then reached agreement with participating practices regarding the number of vaccinations sought from each practice. Health boards also agreed which cohorts of patients would be targeted by practices. Data from Public Health Scotland state that of the 13,078,041 vaccinations administered in Scotland (up to June 2022), over two thirds (69%) of all vaccine doses administered were delivered using either mass or community vaccination centres. General practice administered the second largest proportion of doses (12.7%). Hospital based vaccinations accounted for 7.8% of doses. The remainder of

vaccinations were administered by care homes, pharmacies, and home visits (PB/664 - INQ000283320).

E. Liaison and Communication with the UK Government and Devolved Administrations

Working relationships in England and at the UK level

Chief Medical Officer (CMO) for England

32. While the BMA did not have regular recurring meetings with the CMO for England, the CMO made himself available to meet at the Association's request to discuss issues of concern. This was primarily with the BMA's chair of UK council, often with senior staff from the BMA's Public Affairs team in attendance. Occasionally other elected members of the BMA also attended, e.g. the BMA branch of practice committee chairs.
33. These meetings were held to discuss a range of issues during the pandemic including: availability and adequacy of PPE for healthcare workers; lack of access to testing; and healthcare staff concerns about changes to the Pfizer-BioNTech vaccination rollout.
34. As well as providing an opportunity to raise concerns, these meetings allowed the BMA to better understand the factors which the CMO was considering when advising the UK government. The relationship allowed for a free and frank exchange of views and for the BMA to put forward concerns on behalf of its members.
35. The BMA also wrote letters to the CMO for England raising concerns about the changes to the Pfizer-BioNTech vaccination rollout (PB/271 - INQ000400438).

Secretary of State for Health and Social Care (SoS) and DHSC Ministers

36. The BMA considers that it had good access to the SoS and ministers within the Department of Health and Social Care (DHSC) during the pandemic, including the period covered by this Rule 9 request.
37. In particular, the BMA's chair of the UK council had regular (approximately monthly) meetings with Matt Hancock when he was SoS. The BMA chair of UK council and senior staff also had regular meetings with Minister of State (September 2019 – July 2022) Ed Agar MP, and Minister of State (February 2020 and September 2021) Helen

Whately MP. Senior staff also met with some of these individuals as part of the Social Partnership Forum (SPF) Wider Group (see paragraph 41).

38. The chair of the BMA's General Practitioners Committee England (GPCE) also attended regular meetings with the Parliamentary Under-Secretary of State for Primary Care and Public Health, Jo Churchill MP, between March and June 2020. From this point the meeting agenda changed from solely being to discuss COVID-19, but meetings continued throughout the pandemic which included COVID-19 as a substantive agenda item. The BMA chair of council also met with Jo Churchill when she was deputising for other ministers.
39. The BMA also wrote a number of letters to the SoS and ministers throughout the pandemic.
40. This communication allowed the BMA to raise issues of concern to the BMA and its membership, including those within the scope of Module 4. Specific examples of communication with the SoS and Ministers of State included in relation to:
 - a. Vaccination rollout – a letter dated 29 January 2021 (PB/277 – INQ000400483),
 - b. A phone call on 30 December and WhatsApp exchanges between the then BMA chair of UK council and the SoS on 30 December 2020, 04 January 2021 and 23 January 2021 regarding dosing intervals (PB/541 - INQ000400432),
 - c. Meeting between the BMA GPCE Executive and Maria Caulfield on 02 February 2022 which included discussion on next steps for general practice following the accelerated COVID-19 vaccination booster campaign (PB/792 – INQ000505549).

Department of Health and Social Care (DHSC) civil servants

41. The BMA received updates on issues of relevance from senior civil servants and DHSC representatives through the Social Partnership Forum (SPF). The SPF Wider Group, which existed before the pandemic and is still currently active, is the most senior SPF Group and is chaired by a health minister although during the pandemic,

chairing duties were often delegated to a senior civil servant. During the relevant period, the SPF had a number of sub-groups both ongoing and set up for particular issues. These included:

- a. The SPF COVID-19 Engagement Forum, which was established during the pandemic. Topics of discussion included, among others, PPE, risk assessments, staff testing, staff returning to practice, the physical and mental impact of the pandemic on healthcare staff and the vaccination rollout.
- b. The SPF Strategic Group, which existed before the pandemic, is also currently still active. This group reports into the SPF Wider Group and is co-chaired by NHS Employers and staff side trade unions. It enables more detailed policy discussions at an early stage of development. During the pandemic, this group (and the SPF Wider Group) was attended by the BMA's Head of Professionalism and Guidance and the BMA's Head of Public Health and Healthcare (albeit at times other staff members deputised).
- c. Staff members from the BMA's Public Affairs team were also in regular email contact with civil servants within DHSC to share information or seek clarity on particular issues.
- d. GPCE officers and staff discussed Covid vaccinations among wider operational issues with DHSC civil servants from time to time. For example, in a meeting on 13 October 2021.

NHS England

42. The BMA had significant engagement with senior officials from NHSE throughout the pandemic. This included regular meetings between the chair of the BMA's Consultant's Committee and Professor Stephen Powis, Medical Director for NHSE to discuss COVID-19 issues often weekly/fortnightly. The chair of the BMA's GPCE also attended regular meetings with Professor Powis, along with representatives of some of the Medical Royal Colleges. BMA staff were regularly in contact with NHSE colleagues on matters relating to the pandemic response. While these were often about operational

issues, wider issues about the pandemic response were discussed. This was at both a national and a regional level.

43. At a national level, engagement included raising operational concerns related to the vaccination rollout in England – letters about General Practice IT systems (26 November 2020), prioritisation of healthcare workers for the vaccine amongst the "at risk" category (03 December 2020, 21 December 2020, 29 December 2020), local variation in staff access to the vaccine (21 December 2020), and the need to avoid vaccine wastage (25 January 2021) (PB/287 – INQ000400428, PB/288 – INQ000400429, PB/289 – INQ000400474, PB/290 – INQ000400485, PB/291 – INQ000400481).
44. The BMA GPCE chair and members of the executive team were in regular contact with NHSE's primary care directorate on matters relating to the scope of Module 4. These are detailed in Section I of this statement.
45. On issues related to IT and data sharing in the NHS, the BMA's GPCE met regularly with senior NHSE officials via the Joint GP IT Committee (this is a joint committee between the BMA and RCGP focused on IT issues in General Practice and has a UK-wide remit) and Joint GP IT Liaison Group (this is a smaller subgroup of the full committee) – the former meets on a quarterly basis and the latter on a monthly basis. Issues discussed included hardware provision to GPs to support remote working, patient data flows for COVID-19 testing and vaccination, patient data used for direct care as well as research and pandemic planning.

Regional-level engagement

46. At a regional level in England, regional SPFs (Social Partnership Forums) met frequently (with many meeting fortnightly) to take updates from public bodies including NHSE regional teams and PHE/UKHSA. These meetings were attended by regional BMA staff, such as Regional Coordinators and Industrial Relations Officers and discussed local issues of concern, such as changes to IPC guidance, testing regimes, shortages of PPE or redeployment.
47. BMA Regional Coordinators and Industrial Relations Officers were also engaging at a system level via ICS (Integrated Care System) Partnership Forums, with Health

Education England (via postgraduate deans) and with NHS employers/Trust management. A wide variety of issues were discussed regionally and locally including staff redeployment, movement of staff, establishment of Nightingale hospitals and surge centres, separation of COVID-19/non-COVID-19 care, shortages of PPE and equipment, risk assessments, IPC, shielding, returning to work, impacts of the pandemic on redeployment and early deployment on medical training, vaccination rates and the wellbeing of staff.

General Medical Council (GMC)

48. The BMA had ongoing engagement with the General Medical Council (GMC) throughout the pandemic as it considered the impact of the pandemic on its regulatory remit. This engagement included seeking clarification from the GMC in January 2021 on the use of the Pfizer BioNTech vaccination administered by doctors and their teams in line with the recommendations of the JCVI and the four Chief Medical Officers, but outside of manufacturers' instructions. The BMA was assured that regulatory action would be highly unlikely if GPs followed national guidance (PB/308 – INQ000400511, PB/309 – INQ000400467).

Working relationships with Devolved Governments

Northern Ireland

49. In Northern Ireland, following three years of having no functioning Executive or Assembly, the institutions reformed on 11 January 2020, when UUP MLA Robin Swann assumed the office of Minister of Health under the D'Hondt method. The five-party mandatory coalition in Northern Ireland meant that the full Executive had to agree on measures taken. The Northern Ireland Health Minister would propose actions to the Executive which would then be agreed or not agreed.

50. BMA Northern Ireland had a constructive relationship with the Minister for Health in Northern Ireland, with nine meetings occurring between April 2020 and January 2022. Topics discussed at these meetings include PPE, risk assessments, death in service cover for frontline staff, healthcare capacity, the backlog of care, the impact of the

pandemic on staff and the vaccination rollout. BMA Northern Ireland sent letters to the Minister for Health dated 2 January 2021 and 7 January 2021 raising healthcare workers' concerns about changes to the Pfizer vaccination rollout (PB/092 – INQ000116898, PB/318 – INQ000116901).

51. In addition to regular engagement with the Minister for Health, BMA Northern Ireland engaged (albeit less frequently) with the Chair of the Northern Ireland Assembly Health Committee, Colm Gildernew MLA (Sinn Féin).
52. In addition, between April 2020 and December 2021 the National Director of BMA Northern Ireland had bi-monthly phone calls with the Director of Workforce Policy at the Department of Health Northern Ireland at which issues were discussed including staff vaccination policies and a range of other issues.
53. BMA Northern Ireland also had a specific meeting about the vaccination rollout with the Covid-19 vaccination lead at the Department of Health Northern Ireland on 16 December 2020, followed by a letter dated 5 January 2021 seeking clarification on the rollout of the Pfizer vaccination (PB/319 – INQ000116899).
54. BMA Northern Ireland members attended meetings of the Chief Medical Advisor's Committee (4 November 2020, 15 November 2021), chaired by the Northern Ireland CMO. Covid-19 was an item at these meetings where BMA Northern Ireland members would share views with the CMO and his team. BMA Northern Ireland sent a number of letters to the CMO for Northern Ireland, including on the topic of Pfizer vaccination dosing (PB/323 - INQ000116900). In addition, the Chair of BMA Northern Ireland occasionally communicated with the CMO via text message (PB/325 – INQ000400519).
55. BMA Northern Ireland met with the Public Health Agency on 30 June 2021 and 19 May 2022. Discussion included the impact of Covid-19 on the medical workforce and service provision. BMA Northern Ireland sent letters to the Public Health Agency on 21 October 2020 about flu vaccination supplies and 13 January 2021 about a Covid-19 vaccination surveillance strategy (PB/326 – INQ000400475, PB/327 – INQ000116904).

Scotland

56. BMA Scotland had a good working relationship with the Scottish Government, Cabinet Secretary for Health and senior civil servants throughout the period in question, with regular telephone discussions, scheduled meetings and email exchanges between the BMA Scotland national director at the time and her team, and relevant officials and civil servants.

57. This included participation in a number of regular meetings with the Scottish Government including:

- a. Regular meetings with members of the Directorate for Community Health and Social Care in the Scottish Government. The BMA does not hold minutes of these meetings and, due to staff changes, has not been able to ascertain what was discussed at these meetings.
- b. Weekly meetings between the BMA Scottish GP Committee and the Scottish Government Primary Care Directorate which included discussions on vaccine delivery and the limited role of GP practices in Scotland. These meetings resulted in the Directed Enhanced Service (DES) specification (see sub-paragraph 81.b).
- c. Daily meetings of the Health Workforce Senior Leadership Group, which was established by the Scottish Government in response to the pandemic. These reduced in frequency to two or three meetings a week between April and August 2020, and then moved to weekly or fortnightly following August 2020. Agenda items included vaccinations, covid-19 testing and a wide range of other issues.

58. There was a clear and direct offer from the Cabinet Secretary, Jeane Freeman, to raise immediate problems directly with her office should BMA members become aware of any. This led to occasional meetings between the BMA Scotland chair of council and national director of BMA Scotland at the time with the Cabinet Secretary for Health, for example a meeting on 1 May 2020 which discussed NHS recovery, care homes and the latest BMA Covid-19 Tracker survey. BMA Scotland also had some contact with the Deputy CMO at the time, for example raising concerns about the timing of the second dose of the Pfizer vaccine on 2 January 2021 (PB/442 - INQ000400437).

59. On occasion, communications staff from BMA Scotland met with communications staff from the Scottish Government on an informal basis. This provided staff from BMA Scotland with an opportunity to highlight key issues, for example related to PPE, and to be kept informed about timings of upcoming Government announcements and briefings.
60. To the best of my knowledge, BMA Scotland did not have any direct communication with Public Health Scotland that was specific to the pandemic response, although it is likely that Public Health Scotland would have attended some of the same wider meetings as BMA Scotland.

Wales

61. BMA Cymru Wales maintains ongoing, working relationships with relevant ministers and Welsh Government officials, and this was also the case throughout the period 1 March 2020 to 28 June 2022.
62. BMA Cymru Wales participated in a number of ministerial groups, as well as specific individual meetings with the Minister for Health and Social Services to express member views on the Welsh Government response to the pandemic. Where appropriate, BMA Cymru Wales council / committee chairs wrote to the Minister in relation to specific topics. Engagement with the ministers and Welsh Government officials included:
- a. Partnership forums: The NHS Wales Partnership Forum, a well-established forum in which the BMA participates, and which continued during the pandemic. It is a tripartite group sponsored by the Welsh Government with representatives from the healthcare trade unions for NHS Wales, senior management for NHS Wales and the Welsh Government. The main purpose is the development, support, and delivery of workforce policies at a national, regional and local level. The GP Forum – which also continued during the pandemic – is a similar body for primary care which brings together the BMA General Practitioners Committee Wales, Welsh Government primary care officials and Health Board representatives.

- b. BMA staff also attended weekly formal meetings of the NHS workforce planning cell where the BMA, other Partnership Forum trade unions, NHS Employers Wales representatives and Welsh Government officials were present. Essential information was shared at these meetings and operational decisions were made.
- c. Technical briefings: Welsh Government officials often led the regularly held technical briefings for information sharing with trade unions and the third sector, which took place between April 2020 and February 2021. These technical briefings were an opportunity to ask the Welsh Government questions and focused on regular topics, in particular testing and PPE, and, occasionally, risk assessments for NHS staff. Vaccines were discussed in the early stages at these meetings.
- d. Meetings: On occasion, the Chair of the BMA's Welsh Council met with the Minister for Health and Social Services to raise specific concerns. This includes: a meeting on 17 September 2020 to discuss PPE supplies, flexibility of contract changes in a second wave, the COVID-19 vaccination rollout and plans for non-COVID care; on 17 June 2021, a meeting to discuss the recovery plan; and on 9 December 2021, a meeting to raise concerns about the need for respiratory protective equipment (RPE) for healthcare workers. Discussion between the Minister for Health and Social Services and the chair of BMA Welsh Consultants Committee, along with BMA Cymru Wales staff led to the Welsh Government agreeing to protect staff terms and conditions and issuing of an advisory notice regarding payment for additional hours.
- e. Email and telephone contact between staff: BMA Cymru Wales, primarily via staff rather than elected members, maintained routine contact with Welsh Government civil servants and officials via emails and telephone calls as a means of communication between the Welsh Government and BMA membership.
- f. Written communications with Ministers: Letters were sent to the Minister for Health and Social Services, for example, on a number of issues

including on 08 January 2021 about the Pfizer vaccination rollout (PB/351 - INQ000118674).

- g. BMA Cymru Wales engaged with the CMO and Deputy CMO for Wales intermittently throughout the period in a number of ways. Primarily, letters were exchanged outlining member views on responses to the pandemic. This included a letter on the vaccination rollout on 08 January 2021 (M2B/PB/109 - INQ000118672). There were also occasional direct meetings (e.g. with the CMO on 10 August 2020, and with the Deputy CMO on 25 March 2020 and 14 December 2021), participation in wider meetings (e.g. alongside the Academy of Medical Royal Colleges in Wales), and invitations to the CMO to address BMA committees directly (e.g. the CMO attended the Welsh Public Health Medicine Committee in October 2021). Government officials established regular technical briefings for trade unions and other representative bodies on topics such as testing and PPE (mentioned at sub-paragraph (c) above), and the Deputy CMO would on occasion address these briefings directly. Additionally, there were a small number of WhatsApp exchanges between the BMA chair of council in Wales and the CMO. The first exchange took place between the end of December 2020 and early January 2021 in relation to the rollout of vaccinations to healthcare workers. A further brief WhatsApp exchange concerned the rollout of vaccinations in care homes (PB/555 - INQ000355928).

63. BMA Cymru Wales had various engagement with NHS Wales. The former Chief Executive of NHS Wales, Dr Andrew Goodall, was simultaneously the Welsh Government's Director General for Health and Social Services. Therefore, there is a significant degree of overlap at the executive leadership level between NHS Wales and Welsh Government.

- a. Engagement with the CEO and Deputy CEO of NHS Wales: BMA Cymru Wales sent letters to Andrew Goodall about the recovery of health services (2 July 2020, 19 March 2021), and to raise concerns that some health boards were asking GPs to re-refer patients at a later date instead of maintaining a list of referred patients (23 March 2020) (PB/369 –

INQ000118574, PB/370 – INQ000118688, PB/371 – INQ000400365). A number of meetings also took place with the Deputy CEO of NHS Wales, with topics discussed including PPE, testing, COVID-19 infections, backlogs, winter plans for healthcare delivery, the vaccination rollout, staff wellbeing and the easing of restrictions. These meetings took place on 5 June 2020 (with Andrew Goodall also in attendance), 30 September 2020, 24 November 2020, 5 March 2021 and 20 July 2021.

- b. Joint Oversight Meetings: Joint Oversight Meetings were regular (usually quarterly) meetings between the NHS Wales Director General, the chairs of the BMA branch of practice committees and BMA Cymru Wales staff. Officials and the Deputy CMO for Wales were often present at these meetings. Topics included COVID-19 infections, testing, risk assessments, PPE, the vaccination programme, rotas, shielding healthcare workers, occupational health provision and NHS estates.

- 64. On occasion BMA Cymru Wales communicated with Health Boards and Trusts as employers. This included a letter on 12 January 2021 about the vaccination rollout and access to PPE (M2B/PB/165 - INQ000355938).

F. The BMA periodically surveyed its members about COVID-19 vaccinations to understand views toward potential vaccines and take-up once vaccines were rolled out

- 65. The BMA conducted surveys throughout the pandemic to capture the experiences of doctors on a wide range of issues – including related to COVID-19 vaccination – both before and after the emergence of vaccines.
- 66. This began in 2020 with Covid Tracker surveys which were mostly UK wide and dedicated specifically to issues of the pandemic. Later in 2021, Viewpoint surveys were introduced, which supported research on a wider range of subjects but retained a strong focus on Covid. These surveys were undertaken fortnightly between 6 April and 18 June 2020, before moving to monthly and then bi-monthly. Additionally, during the initial vaccine roll out at the start of 2021, the BMA conducted 10 vaccine surveys of members to monitor access to the new vaccines among the medical profession, in absence of published national data.

67. To inform the BMA COVID-19 Review, the BMA conducted an additional and wide-ranging call for evidence from members, encouraging them to pause and reflect on their experience during the pandemic. The call for evidence was held online between 10 November and 17 December 2021 and received 2,484 responses from across the profession.
68. Between early January and early April 2021, we used specific surveys to monitor the roll-out of both the first and second doses of the vaccine among our members. In each instance, a sample of BMA members was surveyed, using a combination of invitation by email and SMS messaging, with several thousand responding each time. The survey enabled us to track the take up of the vaccine among different groups, with no differences observed between white and ethnic minority doctors, and only very small differences between doctors identified as being at higher clinical risk compared with others in the early weeks of the rollout, before eventually very high levels of vaccination were recorded across all groups.
- a. In an earlier survey dated 9 July 2020 (prior to any vaccines being available), 84% of respondents stated that they would be either very or somewhat comfortable returning to their normal role once COVID-19 vaccines were available – highlighting their importance to doctors and a return to business-as-usual care.
 - b. In a December 2020 survey (by which point two vaccines had been approved for use - Pfizer/BioNTech and Oxford/AstraZeneca), only 19% doctors had been notified about when they would receive a COVID-19 vaccination. In the same survey, over 70% of respondents (n=4,094) reported wanting the vaccine, but not having yet received any details of how they could access one. In particular, doctors who worked in private practice reported greater difficulty in accessing a first dose of the COVID-19 vaccine, as they were not offered a vaccination through their employer.
 - c. Results from a February 2021 BMA survey found that – at the time – 93% of respondents had received the first dose of the vaccine only, with the vast majority (over 90%) receiving the Pfizer/BioNTech vaccine. Of those who had received a dose(s), 82% had not contracted COVID-19 since –

suggesting the tangible, positive benefits of vaccination. Less than 2% of respondents (25 out of 1,543) reported declining the vaccine entirely.

- d. However, within the same February 2021 survey, some respondents raised issues regarding the supply of regular and sufficient COVID-19 vaccinations for their patients. Specifically, 16% reported vaccination sessions needing to be rearranged due to failed deliveries. Additionally, almost 30% of respondents stated that they could have administered more vaccines to patients had supply been greater. Such findings indicated the impact of operational inefficiencies during the early phases of the vaccine rollout.
- e. Overall, however, 90% of medical professionals who responded to the BMA's call for evidence in December 2021 as part of our COVID-19 Review expressed a favourable opinion of the vaccine programme. This is likely to reflect that the UK was the first country to offer vaccinations in early December 2020, thereby protecting its healthcare workers comparatively swiftly. Indeed, a Consultant from Wales described the delivery of vaccination as *"prompt and probably the only success story in the UK's COVID response."*
- f. Additionally, many respondents reported feeling proud to deliver the vaccination campaign, with a GP contractor from England describing it as *"one of the greatest achievements of [their] career"*. Other positives that emerged from the BMA's call for evidence include the ease of booking a vaccine, and a sense amongst doctors of protecting their communities.

G. The BMA published a series of reports on the COVID-19 pandemic

69. The BMA published five 'COVID Review' reports between 19 May 2022 and 28 July 2022, ahead of the Inquiry's public hearings. The reviews followed a call for evidence to BMA members, and in-depth research and analysis – spanning topics such as (health) inequalities, vaccinations, and the impact of the pandemic on doctors. Key findings from each report in relation to COVID-19 vaccination are outlined below (save

for the second report which focused on the impact of the pandemic on the medical profession, and which is therefore not summarised below as it only includes a passing reference to the vaccination programme).

a. The first report, published 19 May 2022, assessed how well the medical profession was protected against COVID-19 – with vaccination eventually playing a key role (PB/013 - INQ000118474). It also covered areas such as infection prevention and control (IPC) measures, personal protective equipment (PPE), and risk assessments – much of which was deemed to be unsuitable and/or insufficient in countering the clinical risks posed by COVID-19 as I have set out in my previous witness statements to the inquiry. However, regarding vaccination specifically, the first COVID Review report found that:

- i. 90% of respondents to the BMA's call for evidence held a favourable view of the vaccination programme, acknowledging that the "*government did some things right*" – such as investing in multiple vaccine candidates and approving them for use early.
- ii. Whilst healthcare workers were rightly among the first to be vaccinated (due to high occupational risk), the BMA heard evidence suggesting differences in access to the first vaccine dose. For example, certain groups such as medical students, resident doctors and GP locums who had not yet been deployed were more likely to report difficulty in accessing their first vaccine. This was also the case for doctors working in private practice, as they were generally not able to access the vaccine via their employers.
- iii. Additionally, pregnant people – including pregnant doctors – initially received conflicting advice on whether to accept the COVID-19 vaccine. This resulted in confusion, and some instances where individuals wanted to be vaccinated, but were unable to do so – even after the advice changed.

- b. The third COVID Review report, published on 26 June 2022, centred on healthcare delivery during the pandemic (PB/015 - INQ000185355). This report highlighted the significant efforts of general practice, who spearheaded the vaccine delivery programme in England via the ES specification.
- i. For example, by the end of October 2021, over 70% of vaccines administered in England had been done by GP practices and community pharmacies (PB/533 - **INQ00065228**). Similarly in Northern Ireland, 38% of vaccines had been delivered by GPs as of 28 March 2022.
 - ii. However, it is worth noting that, whilst such efforts reaped major benefits at the population health level, the vaccination programme resulted in massively increased workloads for GPs. Indeed, a peak of 626,000 vaccinations administered in a single day in England was reached in December 2021 – a remarkable feat, and a testament to the commitment of GPs and their practice teams, who worked many additional hours to deliver mass vaccination efficiently (PB/652 - INQ000479118).
 - iii. The profession, however, faced additional challenges as the booster programme began in September 2021. This rise in demand coincided with comments from the Secretary of State for Health which suggested the UK was “almost back to completely normal” and that GPs should be offering more face-to-face appointments **Parliamentary privilege**
- Parliamentary privilege**
- The BMA responded **Parliamentary privilege** to the Government in September 2021 requesting an urgent meeting

so that GPs could be properly supported to manage workloads (PB/234 - INQ000097914).

- iv. The Government and media's false narrative about GPs "not being open for business" had far-reaching consequences, with GPs and their staff reporting increased levels of abuse from patients. In particular, invitations to be vaccinated appeared to act as a major driver of unacceptable behaviour. Examples of such incidences included the destruction of property within GP surgeries and physical violence against staff.
- c. The fourth report, published 28 July 2022, focused on the effectiveness of the UK's public health response to COVID-19 (PB/016 - INQ000185356). Within the review, the BMA highlighted its contributions to policymaking, in addition to raising some concerns.
- i. For example, the BMA advocated for the staff and older residents of adult care homes to be prioritised for vaccination, followed by those aged over 80, and frontline health and social care workers. Such individuals were ultimately included in the Joint Committee on Vaccination and Immunisation's (JCVI) list of nine priority groups, marking a successful instance of the BMA helping shape better policy.
 - ii. The BMA also raised concerns over anti-vaccine messaging. Indeed, a BMA COVID Tracker Survey from December 2020 found that almost half of respondents (46%) were worried about the impact of such messaging on COVID-19 vaccine uptake.
- d. The fifth and final report of the BMA's COVID-19 Review, published on 28 July 2022, examined the impact of the pandemic on the UK population's health (PB/017 - INQ000185357). This included the impact on the physical and mental health of the population and explored the differential impact on various groups within the population. Regarding the vaccination programme, the report highlighted a number of issues:

- i. It acknowledged that the speed of the development and authorisation of COVID-19 vaccines, followed by the NHS-led rollout, was the biggest success story of the pandemic and that there were positive lessons that could be learnt.
- ii. While overall uptake of the vaccine programme was high, this masked significant disparities, particularly along lines of deprivation and ethnicity. Indeed, the report noted that for some of the groups most at risk of infection and severe symptoms, rates of vaccination were lower than for those groups less at risk.
- iii. Specifically in relation to lower uptake and vaccine hesitancy in some ethnic minority groups, the report recognised that significant efforts had been made by health services, local governments, and community leaders to address the historic mistrust of health services amongst ethnic minority groups who had been let down by institutional racism. It outlined examples of how this had been done, including the use of places of worship as vaccination centres, developing targeted videos with faith and business leaders in those communities, and holding webinars in partnership with community organisations. The report concluded that this likely had an impact on increasing vaccination rates in these communities but did not fully overcome mistrust for all.
- iv. It emphasised the need to learn from these positive examples and ensure that vaccine hesitancy and levels of trust continue to be addressed, and the importance of tailored approaches and culturally sensitive vaccination programmes now and in the future.
- v. Other lessons included the need to ensure long standing practices that deterred people with no fixed address or irregular immigration status from seeking access to healthcare, including vaccines, are addressed and that positive examples of how this was addressed in relation to the COVID-19 vaccination

programme are built upon, such as park-based pop-up vaccination clinics requiring no documentation

H. Pre-pandemic planning, preparedness, capacity and resilience in relation to the vaccination programme

70. I have covered issues related to pandemic preparedness and the under-resourcing of health services prior to the pandemic extensively in my statements relating to modules one, two and three of the Inquiry. In the decade prior to the pandemic, the UK's health services experienced chronic underinvestment, a lack of workforce planning, acute staffing shortages, reduced bed stock, unsafe high bed occupancy levels, year-round capacity issues, growing waiting lists, neglected infrastructure and deteriorating equipment (see for example PB/015 – INQ000185355, PB/113 – INQ000145849, PB/116 – INQ000145865). These fault lines were brutally exposed by the pandemic (e.g. leading to the need to stop significant amounts of non-COVID-19 care due to a lack of capacity, and difficulties in separating COVID-19 and non-COVID-19 patients as a result of the inadequate state of NHS estates).
71. In relation to the vaccination programme specifically, understaffing of health services meant that there was less capacity to deliver additional mass vaccinations which meant that GPs and their teams (delivering the bulk of the vaccinations) took on the increased workload of delivering vaccines while maintaining non-COVID and COVID care. Early planning helped mitigate some of these pressures and the BMA was involved at an early stage to ensure vaccines could be delivered at pace. I cover this in more detail in the next section of this statement.
72. This lack of resilience in the health services and workforce capacity resulted in many healthcare professionals – including GPs and practice staff – having to work additional hours, whilst continuing to juggle other demands. This contributed to stress and burnout amongst BMA members, with 84% of GPs reporting in 2022 that their workload had “*increased a lot*” since the pandemic, and that this work was stressful in nature (PB/665 - INQ000479131).
- a. This surge in workload occurred against the backdrop of falling numbers of GPs. For example, by December 2020 (when the vaccine was first

offered) England had the full-time equivalent of 28,036 fully qualified GPs – down from 29,364 in September 2015. By July 2021, the situation had worsened considerably, with just 27,750 fully qualified GPs (PB/673 - INQ000479139). This drop in workforce limited GPs' capacity to deliver non-COVID and COVID care alongside delivering vaccinations, highlighting the system's lack of preparedness for a large-scale vaccination programme. The situation was markedly made worse because of the effective shutdown of non-urgent, non-COVID care in hospitals, which swamped general practice with additional patients left waiting for outpatient review or in-patient treatment, a situation from which the UK has not recovered.

- b. The issue remained unaddressed long into the pandemic. On 12 December 2021 – a year after the launch of the vaccination programme – the BMA was still raising concerns with NHSE regarding GP capacity to vaccinate in some areas. Specifically, the then chair of the GPCE held an urgent meeting with Dr Nikki Kanani (then Deputy Lead for the NHS COVID-19 Vaccination Programme). The GPCE Chair requested the temporary suspension of the pressure on GPs to provide face to face appointments which were not clinically necessary to instead free up GPs to focus on clinical tasks, as well as additional support through commissioner teams, appraisers and CQC advisors.
- c. In July 2024, the average number of patients per GP had increased by 18.3% since September 2015 to 2,293 (PB/805 - INQ000505536). This means that staffing for future vaccination programmes should be considered as part of pandemic planning exercises and makes it even more important for health services to be adequately staffed and the decline in GP numbers to be addressed so there is some capacity in the system to deliver any required future vaccination rollout.

I. The BMA's role in the COVID-19 vaccination programme

The BMA was closely involved in the development of the policy, strategy and design of the COVID-19 vaccination programme and at an early stage

73. Across all the four UK nations, the BMA engaged with the COVID-19 vaccination programme early on – prior even to a vaccine becoming available. The BMA was a natural partner as the BMA's members delivered routine vaccination and immunisation programmes prior to the pandemic (as set out in section C). The BMA in all four nations has had long-standing and close-working relationships with NHS/HSC bodies which meant that engagement and collaboration was able to happen at an early stage. GPs in all four nations have developed incredibly effective, slick and efficient systems to deliver large vaccination programmes (such as they do for seasonal flu).
74. The BMA in all four UK nations provided input into the policy, strategy and/or design of the COVID-19 vaccination programme. This was done via meetings with relevant government and health service bodies and contributing to guidance documents.

England

75. In England, the BMA had been lobbying NHSE and DHSC, prior to the vaccine programme being announced, that GP teams should be the primary delivery mechanism for the vaccination programme, rather than a separate body. The BMA's GPCE was engaging regularly with NHSE. For instance, the Chair of GPCE attended a primary care flu delivery group meeting on 5 August 2020. Topics discussed included the data flow requirements needed to run an effective, combined Flu and COVID-19 vaccination programme, as well as the risks of using older/returning staff as vaccinators.
76. Between 2020 to 2022, the BMA engaged extensively with NHSE on matters relating to vaccinations. This was done through:
- a. NHSE COVID-19 vaccination meetings, which took place regularly. From 2020 to 2022 these were held several times a month and were attended by GPCE executive members and staff.

- b. The Joint GP IT Committee and its Liaison Group meetings (see paragraph 45 above for further information on these groups). These meetings covered General Practice information technology systems and issues related to the collection and sharing of patient vaccination data. The meetings took place fairly regularly, with full committee meetings occurring four times a year, and Liaison Group meetings occurring eight to 10 times a year. These were attended by GPCE executive members and staff.
- c. Calls scheduled outside of the vaccination meetings with NHSE staff.
- d. Letters and email exchanges with NHSE staff (see for example PB/287 - INQ000400428, PB/289 - INQ000400474 and PB/699 - INQ000400485).

77. The BMA GPCE, in conjunction with NHSE, agreed an Enhanced Service (ES) specification, whereby general practice would lead the delivery of the COVID-19 vaccination programme. The BMA published guidance for general practitioners on 09 November 2020 (PB/677 - INQ000480982), outlining what the indicative ES specification would involve, what was expected of practices, and the support available to GPs to enable this work. The guidance also covered important issues such as financial compensation for the additional work done by GPs and other practice staff in delivering the vaccination programme (including the payment amount and mechanism), as well as how best to prioritise the additional workload. Due to the fast pace of this work, many discussions between GPCE and NHSE regarding the COVID-19 vaccination programme were conducted over the phone. As such, my account of these discussions is accurate to the best of my knowledge and as our records show.

78. Primarily via the BMA GPCE, the BMA provided the following input into the vaccination programme:

- a. Commenting extensively on the COVID-19 vaccination programme ES specification. For example, through:
 - i. A vaccination meeting held on 30 October 2020 where discussion centred around the proposed model, proposed cohorts for inclusion in the ES specification, designation of sites, delivery, workforce and training, and funding.

- ii. Email and document exchanges where GPCE executive members commented on various versions of the draft ES specification throughout the different phases of the programme in England, from 2020 to 2022.
- iii. In November 2020, the BMA commented on one of the first versions of the ES specification and draft designation process letters that would be sent to the profession and Primary Care Network (PCN) sites on the vaccination programmes' next steps. The BMA and NHSE went back and forth with several versions of the specification, with the BMA highlighting various concerns regarding, for example, patient record sharing, processes for vaccinating housebound patients, payment arrangements (as detailed further below from paragraph 93) and unpredictability of vaccine supply (PB/793 – INQ000505537, PB/678 – INQ000480983). Ultimately, agreement on the ES specification was reached between GPCE and NHSE, and the ES specification was first published by NHSE on 1 December 2020 (PB/794 – INQ000505539).
- iv. In January 2021 further drafts of updated versions of the ES specification were shared for comment with GPCE by NHSE, following the approval of the Oxford-AstraZeneca vaccine and the change to the vaccine dosing interval. Regarding actions required by participating GP practices in relation to the dosing interval change, the BMA highlighted concerns including that the short length of transition to implement the change between doses from three weeks to 12 weeks risked practices withdrawing from the vaccination programme due to the lack of flexibility in the way it was being managed, and that there was an apparent lack of understanding of the mental and physical impact the change would have on very elderly patients directly affected by it. These particular concerns were shared on 5 January 2021 (PB/702 - INQ000481012), and the BMA did find 'significant improvements'

in the revised draft. The final version of the updated ES specification for the first phase of the COVID-19 vaccination programme was shared with GPCE by NHSE on 7 January 2021 (PB/705 - INQ000329412).

- v. On 15 February 2021 (PB/721 - INQ000481033) and 27 May 2021 (PB/736 - INQ000481051), NHSE shared a document with the proposed amendments to the ES specification with the BMA GPCE for review, the latter of which came after the JCVI's announcement that second doses should be accelerated from 12 weeks to eight weeks.
- vi. On 24 June 2021 (PB/739 - INQ000481055, with attachment PB/738 - INQ000481054), and 20 and 30 July 2021 (PB/744 - INQ000481064, PB/747 - INQ000481070), NHSE further requested the BMA's input into the proposed phase 3 of the ES specification, to which the BMA provided feedback. One of the changes to the specification followed the JCVI announcement on vaccinating particular groups of 12 to 17-year-olds and on the extension of phases 1 and 2 of the vaccination programme.
- vii. On 4 August 2021 (PB/748 - INQ000481074), NHSE contacted the BMA regarding draft ES specifications for vaccinating children between 16 to 17 years of age, and other questions raised by the BMA around the vaccinating of immunosuppressed 12 to 15-year-olds. The BMA also raised a question on support for finding vaccination venues.
- viii. In September 2021 (PB/751 - INQ000481084, PB/752 - INQ000481089, PB/755 - INQ000481093), NHSE were in communication with the chair of GPCE, regarding proposed amendments to the ES specification which were in line with confirmed and anticipated advice on vaccinating children and potential plans to use the School-Aged Immunisation Services (SAIS) for vaccinating that cohort.

- ix. In November 2021 (PB/758 - INQ000481098, PB/759 - INQ000481100), NHSE again invited the BMA to comment on the proposed changes to phase 3 of the specification. The BMA also responded to draft amendments to the ES specification by NHSE in December 2021 (PB/768 - INQ000481112, PB804 - INQ000481113). Amendments included changes to funding, for example in the item of service fee (as detailed further below from paragraph 106).
 - x. In January 2022 (PB/771 - INQ000481117 with attachment PB/772 - INQ000481118, PB/775 - INQ000481122 with attachment PB/774 - INQ000481121), drafts of the specification were again shared with the BMA for feedback, which included reference to anticipated advice from JCVI about boosters for 80+ year olds and care home residents, as well as amendments regarding extending the period for £10 supplements for vaccinations to severely immunosuppressed individuals.
 - xi. Further versions of the amended draft ES specification for phase 3 were shared in February 2022, with the BMA sending back comments (PB/781 - INQ000481130, PB/782 - INQ000481131 with attachment PB/783 - INQ000481133). A further draft ES specification for phase 3 and phase 4 was shared with the BMA on 4 March 2022.
 - xii. In May 2022, at NHSE's request, the BMA commented on phase 5 of the ES specification for the Autumn 2022 COVID-19 vaccination programme. On 27 May 2022 NHSE requested that the BMA approve a statement saying that the specification was agreed between NHSE and GPCE (PB/786 - INQ000481137). The BMA declined this statement as 'not all aspects of the ES have been agreed' (PB/787 - INQ000481139) – this is detailed further below from paragraph 115.
- b. Feedback into NHSE letters that would be sent to the profession/PCN sites in regard to guidance and the ES specifications. For example:

- i. The Chair of GPCE fed into a working draft of a letter from NHSE that would be sent to practices that chose not to participate in the vaccination programme. The letter was about vaccinating eligible patients from these non-participating practices elsewhere (PB/695 - INQ000481003, PB/696 - INQ000481004). There was a perception among some practices that the funding would not cover the additional work and they did not have sufficient workforce to deliver vaccinations and their usual work as well. The numbers of practices that chose not to participate were initially very small, but they increased in future phases of the vaccination programme, in 2023/4 when funding was cut, and particularly in areas of deprivation where there was greater vaccination hesitancy and refusal so uptake was lower. The BMA is not aware of any national schemes to offer incentives or assistance at the time to support practices/PCNs in areas of deprivation to join or remain in the vaccination programme.
- c. Feedback into other letters, for example:
 - i. On 18 February 2022, NHSE shared a letter that would be sent to Trusts or Integrated Care Board stakeholders regarding vaccinations for 5 to 11-year-olds and asked GPCE to share any concerns. The contents of the letter was discussed via telephone between GPCE and NHSE according to the related email thread (PB/780 - INQ000481128, with attachment PB/779 - INQ000329594).
- d. Questions which GPCE raised to NHSE and NHS Digital (NHSD) through emails or meetings with regards to other aspects of the vaccination programme, such as:
 - i. Concerns about technology for data collection and transfer of data, logistics and IT issues, and payment issues, such as with Sonar and Pinnacle, MYS and EMIS – which are IT systems used within general practice record patient and practice data. For example:

1. On 18 November 2020, the BMA provided comments on a paper about COVID-19 vaccination data and payment flows from NHSE.
2. The BMA reviewed the 'COVID-19 vaccination solutions one page requirements' guidance on 30 November 2020, which documented the requirements required of General Practice IT Solutions to support the COVID-19 mass vaccination campaign at local/GP/PCN level (PB/687 - INQ000480993).
3. Meetings took place in November and December 2020 to explain the mandating of the use of Sonar and Pinnacle software which were used to record vaccination data (PB/681 - INQ000480986), and the issues regarding Pinnacle outage (PB/693 - INQ000481001).
4. Email exchanges with NHSE and NHSD regarding issues with the point of care systems recording COVID-19 vaccinations. There were various topics of discussion over the course of months. One was in regard to manually coding onto EMIS due to an error, to which the interim solution was for a PDF to be returned to the EMIS workflow manager, requiring no further input by the GP practice (PB/697 - INQ000481006, PB/698 - INQ000481007). Another issue was about the Pinnacle/MYS vaccination data being incorrect, such as data being linked to the wrong patient (PB/732 - INQ000481047), particularly around care homes and housebound patients (PB/726 - INQ000481041). In April 2021, NHSE advised the BMA of an upcoming NHS Business Services Authority COVID-19 Vaccine Assurance Process which sought to identify possible anomalies in the information recorded in Pinnacle (from December 2020 to February 2021) (PB/730 - INQ000481045). The aim was to confirm if payments made reflected the volume of activity recorded. In May 2021, the Chair of GPCE at the time contacted NHSE to seek clarification about proposals that would direct patients

to their practices if they wanted to correct their vaccination data. NHSE shared that this would only happen if there was an issue with the data around the patient's vaccination and was an interim solution. In May 2021, the Chair of GPCE offered a meeting to discuss these issues because not all GPs and their teams could access Pinnacle to correct any inaccuracies (PB/734 - INQ000481049).

5. GPCE requested meetings to discuss vaccination data extraction directly *from* General Practice systems in order to support COVID-19 vaccinations (PB/680 - INQ000480985, PB/688 - INQ000480995).
6. In March 2021, the GPCE raised concerns about getting vaccination data *to* General Practice systems, such as with second dose delivery for those who had their first dose administered in hospitals, and, related to that, concerns about how Pinnacle captured data to inform General Practice about the quantities needed for supply (PB/725 - INQ000481040), to which NHSE responded that patients should return to the same location for their second dose, with exceptions.
7. Mis-recording of COVID-19 vaccinations and the impact this had on practices in terms of medical and legal risk. (PB/743 - INQ000481063).
8. Though the BMA had fed back and raised multiple points regarding the recording of the COVID-19 vaccination data, it was felt that the BMA was invited to input into the design of data collection for the vaccination programme too late in the process. Had the BMA been consulted at an earlier stage, it is possible that GPCE would have advised against using Pinnacle as the point of care IT system due to a) it being untested in general practice and b) general practice being the principle driving force behind early vaccination efforts. Had

an alternative system supplier been selected, improvements in efficiency and data capture early on may have enabled a higher degree of productivity and fewer wasted vaccinations (see further at paragraphs 123 to 130 below).

ii. Concerns around vaccine supplies and delivery. For example:

1. On 13 January 2021 the BMA contacted NHSE to highlight various live issues with the vaccination programme rollout, including logistics issues related to last minute vaccine delivery notifications and cancellations. A call was then held between NHSE and BMA staff, which was followed up with an email response in which NHSE acknowledged the issues and stated that the process was being refined daily, and that a 'push' model was being adopted to give PCNs as much notice as possible of future deliveries. NHSE also noted that a bug had been discovered in the vaccine delivery notification system which had since been addressed (PB/712 – INQ000481023).
2. 'Delivery & logistics issues' were also raised as an agenda item by the BMA for a regular call on COVID-19 vaccination between GPCE and NHSE on 3 February 2021.
3. Via an exchange of emails between 27 February and 3 March 2021, NHSE updated the BMA on the number of PCN sites not receiving any vaccine in first two weeks of March 2021 – 22 sites during the week commencing 1 March 2021 and 79 sites during week commencing 8 March 2021, of a total of 1,034 PCN sites, would not be receiving any vaccine and these sites had been chosen not to receive any vaccine for first doses based on criteria such as remaining priority cohorts still to vaccinated (PB/796 – INQ000505545). The BMA raised second dose vaccine delivery in an email to NHSE on 1 March 2021, stating that sites were not receiving information about delivery schedules and so were not able to

book patients in for their second dose, and patients were consequently ringing practices to enquire about booking their vaccine which was adding to practice workloads. On 2 March 2021, the BMA raised second dose delivery dates and bookings as an agenda item for a regular GPCE/NHSE call held on 3 March, as some practices were not able to book in second dose patients due to a lack of confirmation of delivery dates. In a reply also on 2 March 2021, NHSE flagged a statement made by the SoS in the House of Commons that day on the upcoming increase to vaccine supply. A letter dated 2 March 2021 to PCN-led local vaccination sites from NHSE detailed vaccine supply plans, including an increase in supply throughout March 2021 (PB/797 – INQ000481037).

iii. Concerns around patient invitation letters:

1. By email on 13 January 2021, the BMA noted confusion around patient letters and GP vaccination sites versus mass vaccination sites (PB/712 – INQ000481023). In response by email following a call, NHSE stated that letters had been amended following feedback, and that the BMA had requested that NHSE add information to the landing page of the national booking system to show patients which PCN sites were live.
2. On 27 January 2021 the BMA provided suggested changes to a draft patient vaccination booking information letter to make clear the difference between patient actions required for booking their vaccination at their local GP practice or at a community pharmacy or vaccination centre (PB/798 – INQ000505541).
3. Communications to patients, specifically the timetable for patient letter drops and national booking services following reports of patients being told to phone their GP practice to book their second dose vaccination rather than waiting for

their GP practice to contact them, was raised as an agenda item for a call held on 10 February 2021 (PB/799 – INQ000505542).

- e. Concerns about the rollout of the second dose of the Pfizer vaccine (see sub-paragraph 78.a.iv).
- f. Plans for general practice for the vaccination booster programme and potential changes to the GP contract (PB/761 - INQ000329557). The BMA had concerns about this due to the risk of increased NHS pressures and reducing GP capacity to vaccinate (PB/767 - INQ000481111):
 - i. In a press release of 1 July 2021 (PB/640 - INQ000479106), the Chair of GPCE responded to NHSE's guidance (PB/740 - INQ000329507) on the COVID-19 booster vaccination programme. He highlighted the critical role GP practices play in community health, citing successful flu jab campaigns even during the pandemic and their leading role in the COVID-19 vaccination programme. He also stressed the need for support and flexibility for GP practices to participate in the booster campaign effectively. He emphasised the importance of allowing GP teams to administer boosters within their own practice buildings to streamline the process and reduce administrative burdens. This was a significant issue for GPs as, due to the 'PCN Grouping' system which the ES specification was based on for the delivery of the COVID-19 vaccination programme, which required GP practices to work together as groups (which could include existing PCNs), vaccinations were only delivered to a single PCN site and were not able to be moved to other sites, such as GP practices, to give vaccinations in places most patients were familiar with (and where they would have received their flu vaccination). GPCE requested that phase 3 of the COVID-19 vaccination programme be delivered at practice level, rather than through PCN Groupings, but NHSE stated that it was necessary to retain the PCN Grouping model due to the requirement to expand capacity in the booster

network, supply chain limitations and likely vaccine characteristics (PB/800 – INQ000505546). Finally, he urged trust in and empowerment of GP practices to lead vaccination efforts for long-term public protection against COVID-19. By contrast, in Wales, as detailed above in paragraph 30, all 392 active practices were delivering COVID-19 vaccinations under a Primary Care Contracted Services: Immunisations specification from their local health board. In a draft of an updated version of the ES specification shared with GPCE by NHSE on 23 May 2022, NHSE added wording around the use of ‘Satellite Designated Sites’ to support greater vaccine delivery to patients at practice level, noting that this proposal was still being discussed with MHRA (PB/784 – INQ000481135).

- ii. In a further press release of 14 July 2021, the Chair of GPCE expressed his view on the ES specification for the delivery of the COVID-19 booster in England. He stressed the importance of GP practices in vaccination efforts as demonstrated by the annual flu and COVID-19 campaigns. He expressed concern for the lack of support for COVID-19 vaccination within the GP premises which he said would give patients confidence, particularly if they could get both their flu and COVID-19 vaccinations at the same time at their GP practice. He also criticised NHSE for refusing to give GPs the flexibility to lead in a way that works best for their communities (PB/789 - INQ000099408). He argued that this could limit the impact of the booster and vaccine uptake, criticised NHSE’s inflexible ‘command and control’ approach but affirmed GPs’ commitment to vaccination as a key strategy for the pandemic’s end.
- iii. Following discussions with, and input from, GPCE on 7 December 2021 NHSE published a letter to GP practices and commissioners setting out support NHSE was providing to free up GPs, practice teams and PCNs to advance the vaccine rollout through

temporary GP contract changes (PB/764 - INQ000329558). The letter set out how GPs and PCNs would be supported to expand the COVID-19 vaccination programme given the emergence of the highly transmissible Omicron variant. It included recommendations proposed by the BMA, such as changes to the Quality and Outcomes Framework (designed to reduce bureaucracy and manage high workloads). Most significantly, such measures freed up capacity to support the COVID-19 vaccination programme.

Wales

79. Across the devolved nations, the BMA's engagement with the vaccination programme took slightly different forms. In Wales, for example, the BMA participated in a 'Workforce Sub-Group' from July 2020, set up by the Welsh Government. Additionally, BMA Cymru Wales regularly attended the COVID-19 Vaccine Delivery Programme Board, where issues such as vaccine prioritisation, its storage and distribution, and communications were discussed. Furthermore, the Welsh General Practitioners Committee (GPC Wales) was engaged in extensive discussions with Welsh Government officials about the vaccination delivery mechanism in GP practices.
80. BMA Cymru Wales fed into the COVID-19 vaccination programme through regular meetings, calls, emails and letter exchanges. The BMA would keep in contact with the Welsh Government, NHS Wales, Health Education and Improvement Wales (HEIW), and the CMO. For example:
- a. On 17 September 2020, the Chair of the BMA Welsh Council met with the Health Minister to discuss COVID-19 vaccinations and how they would be administered (M2B/PB/097 - INQ000118619).
 - b. On 24 November 2020, the Chair of the BMA Welsh Council met with the Deputy Chief Executive of NHS Wales, where the delivery of the COVID-19 vaccine was discussed amongst other topics (M2B/PB/068 - INQ000118649).

- c. On 8 January 2021, the Chair of the BMA Welsh Council wrote a letter to the Welsh CMO raising concerns over delays in COVID-19 vaccination rollout in care homes with any positive cases (M2B/PB/109 - INQ000118672).
- d. On 8 January 2021, the BMA met with the then Minister for Health and Social Services, to raise concerns on the Welsh Governments' Pfizer Vaccine dose spacing approach, noting member concerns at delays and departure from clinical trial administration timings. A letter (see subparagraph 172.b) was sent on the same day to thank the minister for the meeting (PB/351 - INQ000118674).
- e. On 12 January 2021, the BMA wrote to the Health Minister and Healthcare Chief executives on the COVID-19 vaccine schedule. The BMA then wrote to the 59 other Members of the Senedd (MS) to make them aware of our concerns about the decision to delay the second dose of Pfizer, calling for all frontline healthcare staff to receive their second dose as soon as possible (PB/708 - INQ000481019, with attachments PB/709 - INQ000481020 and PB/351 - INQ000118674).
- f. On 22 January 2021, the BMA attended a meeting with the health minister about vaccine delivery to healthcare staff (M2B/PB/102 - INQ000118680).
- g. On 27 January 2021, the Chair of the BMA Welsh Council sent a letter to Angela Burns MS to congratulate her on her re-appointment as Shadow Health Minister, and to highlight concerns about the Welsh Government's approach to vaccination dose spacing for healthcare professionals. (PB/715 - INQ000481027).
- h. On 5 February 2021, the Chair of the BMA Welsh Council wrote to the Director General of Health and Social Services and NHS Wales Chief Executive to flag operational issues with the vaccination programme, for example with the use of WIS (the Welsh Immunisation System, used for scheduling and recording COVID-19 vaccinations in Wales), and timely

entry of data, the application of invitations for the tiered risk groups, and concerns with tier 6 (PB/718 - INQ000481030).

- i. On 13 July 2021, the BMA attended a meeting with HEIW, where COVID-19 related issues, including the booster vaccination programme were discussed (PB/742 - INQ000481061, PB/741 - INQ000481060).
- j. On 20 July 2021, the Chair of the BMA Welsh Council met again with the Deputy Chief Executive of NHS Wales, where the COVID-19 autumn vaccination campaign was discussed, amongst other topics (M2B/PB/139 - INQ000356005).
- k. On 11 January 2022, the BMA sent a letter to the Welsh Government regarding GP involvement in the COVID-19 booster campaign, which stated GPC Wales' disappointment at the lack of supportive ministerial statements for the increased role of general practice during the booster campaign, and also highlighted the benefit of GP involvement in the vaccination programme while calling for further discussion on vaccination planning (PB/773 - INQ000481120).
- l. In addition to communications with the Welsh government and individual ministers, the BMA was a part of several groups which would discuss the COVID-19 vaccination programme. These groups included:
 - i. The Welsh Government Joint Oversight Meeting (JOM), which would often include the COVID-19 vaccination programme, and its different phases/boosters, as well as the logistics of running it as part of the discussion.
 - ii. The Vaccination Workforce (planning) cell subgroup meetings, which would discuss vaccination planning.
 - iii. The Wales Government COVID-19 Vaccination Stakeholder Board Meetings, which would discuss topics around the COVID-19 vaccination programme such as vaccine supply and dosing schedules for vaccination centres.

- iv. Wales Information Governance Board meetings, where information governance in relation to the vaccination programme would be on the agenda.
- v. The BMA had also provided extensive input via letter and email exchanges, as well as calls, with Alex Slade, Deputy Director of the Primary Care Division in the Welsh Government, on the Primary Care Contracted Services: Immunisations (PCCS:I) specification throughout 2020 to 2022. For example, on 9 December 2020, the Welsh Government shared a letter on the PCCS:I specification (PB/689 - INQ000480997, PB/690 - INQ000480998). The Chair of GPC Wales responded with a letter on 10 December 2020 (PB/691 - INQ000480999), which expressed BMA Cymru Wales's disappointment that the Welsh Government were not pursuing the proposal BMA Cymru Wales had put forward in an earlier meeting for a practice-based NES (National Enhanced Scheme) and an SLA (Service Level Agreement), which, as indicated in the letter response, was a preferred solution amongst the BMA and the local health board representatives. There were subsequent email exchanges between the Welsh Government and the GPC Wales through 10 December to 14 December, after which a final PCCS:I specification was shared on the 14 December when the BMA agreed to undertake COVID-19 vaccination in conjunction with health board plans (PB/692 - INQ000118659).
- vi. On 17 March 2021, a draft specification on the PCCS:I AstraZeneca Oxford primary care COVID-19 immunisations and the Moderna primary care immunisation were shared (PB/729 - INQ000481044, PB/728 - INQ000481043).
- vii. On 20 July 2021, a draft specification on the PCCS:I Pfizer BioNTech was shared (PB/744 - INQ000481064), with the final version being shared on 29 July 2021 (PB/746 - INQ000481067,

with attachments PB/745 - INQ000481066 and PB/642 - INQ000479108).

- viii. On 11 August 2021, a letter was sent to primary care contractors with directions and specifications relating to the PCCS:I. This letter was issued to health boards and they asked the BMA to help with disseminating the letter (PB/749 - INQ000481078, PB/750 - INQ000481079). The BMA noted that our comments were relayed but the Wales Government continued with the specification regardless.
- ix. On 04 February 2022, updates to the PCCS:I were shared with amended directions (PB/658 - INQ000479124).

Scotland

81. BMA Scotland were involved in several groups which potentially fed into Scotland's vaccination programme. Such groups are:

- a. The Scottish Governments' Mobilisation Recovery Group, where agenda items would sometimes include the COVID-19 vaccination programme and workforce planning. The group met several times per week. The BMA acted as a core member of the group from August 2020 onwards, at the invitation of the Scottish Government. While this group was not specific to COVID-19 vaccination, discussion points included the role of Public Health Scotland in vaccine delivery and vaccinator workforce planning.
- b. BMA Scottish GP Committee weekly meetings with Scottish Government Primary Care Directorate where the limited involvement of GP practices in the vaccination programme was agreed leading to the DES specification (PB/685 - INQ000480991).
- c. Scottish Government's Workforce Senior Leadership Group (WSLG) where agenda items would sometimes include discussion on the COVID-19 vaccination programme. For example, after a call for agenda items on 12 January 2021 (PB/791 - INQ000481047), the BMA requested an

update on Scotland's strategy for monitoring the vaccination process, particularly regarding surveillance and analysis.

- d. Pandemic Response in Adult Social Care Group (PRASCG), which often discussed vaccinations in care homes, vaccine safety communication, and more, on the agenda.
- e. National Oversight Group meeting, where agenda items would sometimes include discussion on aspects of the vaccination programme. For example, the meeting on 16 September 2021 had papers which included subjects such as pharmacotherapy, and vaccination transformation programme (see for example papers PB/737 - INQ000481053, PB/753 - INQ000481091 and PB/754 - INQ000481092).
- f. Outside of these meetings, the BMA raised several points of concern with the Scottish government as and when relevant, such as through letters and meetings. For example, on 17 December 2020, the BMA met with the Scottish Government as part of the PRASCG and discussed COVID-19 vaccinations in care homes, and administration, amongst other topics (PB/694 - INQ000324646). From 23 to 30 November 2021 the BMA fed into a letter to the GP profession from the Scottish Government, NHS Scotland, and Public Health Scotland on 'Improving Provisions of In-Hours GP Activity Data' (a draft of this letter is exhibited at PB/760 - INQ000481102). The letter shares the aim to extract vaccine uptake data from GP practices through the COVID-19 vaccination programme to analyse the data gathered and derive useful information and intelligence. The BMA highlighted its concerns regarding quality of information.
- g. BMA Scotland also raised concerns with Scottish Government around the rollout of the second dose of the Pfizer vaccine (see paragraph 171).

Northern Ireland

82. In Northern Ireland, there was engagement with the NI General Practitioners Committee (NIGPC) on the COVID-19 vaccination roll out.

83. During November 2020, NIGPC representatives had meetings with the Head of GMS at the Northern Ireland Health and Social Care Board (HSCB) about the planning of the vaccination programme and the format of the enhanced service for COVID-19 vaccination.

84. On 26 November 2020, the Head of GMS at the HSCB wrote to all Northern Ireland GP practices setting out the planned programme (PB/682 - INQ000480988). This letter stated:

'The Northern Ireland General Practitioners Committee (NIGPC) have agreed in principle with Department of Health and the Health and Social Care Board that GPs will provide the COVID-19 vaccination programme in the initial phase for people over 80 years old not living in a care home. In the later phases GPs are expected to be the main system for those in clinical risk groups and people over a certain age'.

85. On 12 January 2021, the Department of Health (NI) published a detailed timetable for delivery of vaccinations to prioritised groups. GPs in Northern Ireland were primarily administering the Astra Zeneca vaccine and Trusts were primarily administering the Pfizer vaccine. This was due to the low temperature storage needs of the Pfizer vaccine, whereas the Oxford-AstraZeneca vaccine was considered easier to store and distribute. Trust centres could maintain the required low temperature for Pfizer more easily than GP practices, who were therefore supplied with Oxford-AstraZeneca vaccine instead (PB/621 - INQ000479087).

86. Supplies of the Pfizer vaccine were distributed solely to Trusts to vaccinate the vaccinators, care home residents and health care workers. This started on 8 December 2020 and by 6 January 2021, 91% of the 483 care homes had been visited by mobile vaccination teams. The Department of Health (NI) said there had been an uptake level of more than 90% among residents and about 80% among staff (PB/627 - INQ000479093).

87. After approval on 30 December 2020, supplies of the AstraZeneca vaccine were distributed to GP practices with a small amount going to Trusts to deal with people with allergies. Practices started vaccinating the over 80s week commencing 4 January 2021.

88. On 22 January 2021, the Head of GMS at HSCB wrote to GPs in Northern Ireland confirming the move to the next clinical priority group (PB/714 - INQ000481026). Communications with the Board continued with feedback from practices being reported in as the programme progressed.
89. The Chair of the BMA Northern Ireland Council wrote to the Northern Ireland Health Minister Robin Swann on 02 January 2021 (PB/092 - INQ000116898) expressing concern at the delay between the first and second dose of the Pfizer vaccine for doctors, reflecting concerns expressed by BMA members.
90. On 12 January 2021, the Chair of the BMA Northern Ireland Council wrote a similar letter to the Deputy Chair of the Northern Ireland Assembly Health Committee on the delay of the second Pfizer vaccine (PB/790 - INQ000116902).
91. The Chair of the BMA Northern Ireland Council wrote to the Northern Ireland Public Health Agency on 13 January 2021 asking for details of the COVID-19 vaccine surveillance strategy in Northern Ireland (PB/327 - INQ000116904).
92. On 1 October 2021, the NIGPC Chair wrote to the Northern Ireland Chief Medical Officer stating that GPs remained committed to administering both COVID-19 boosters and seasonal flu vaccines but raising concerns about the effectiveness of the Vaccinations Management System (VMS) recording system and expressing hope that the next VMS update would improve the situation (PB/675 - INQ000480980).

The BMA negotiated the funding arrangements for vaccine delivery in general practice

England

93. The BMA's GPCE was in regular communication with NHSE regarding the development of, and subsequent amendments to, the COVID-19 Vaccination Programme ES specification which included the funding arrangements for the vaccination programme.
94. As independent organisations holding a contract with NHSE to provide services, it was crucial to the ongoing provision of primary care that GPs were remunerated for non-contractual services to enable them to continue functioning and provide those services stipulated by their contract. While there were some issues with payments to GPs (as

set out at paragraph 105 below), at no point did these payment issues stop GPs from delivering vaccines.

95. Payment rates for administering COVID-19 vaccinations changed at multiple points during the vaccination programme. The Item of Service (IoS) payment was originally set at £12.58 per dose and remained at this rate until it was reduced to £10.06 in September 2022, other than a period between December 2021 and January 2022 when the IoS rate increased to £15-£20 to enable the rapid administration of booster vaccines in response to the Omicron variant. Supplementary payments were also payable at various times for vaccinations administered to older adult care home patients and staff, housebound patients, and severely immunosuppressed patients, usually set at £10 per vaccination although this rate also varied. Supplementary payments were payable to support practices to administer vaccines to these vulnerable groups in their homes, rather than in a practice vaccination centre.
96. GPCE agreed with NHSE that £20 million of NHS funding be made available to support vaccination sites with the one-off costs of setup and it was involved in discussions around what this funding could cover, such as internet broadband set up costs, as per comments made in a draft ES document received by GPCE from NHSE on 30 November 2020 (PB/686 – INQ000480992).

Negotiations on the Item of Service fee for COVID-19 Vaccinations

97. The BMA proactively made the case that the COVID-19 vaccination should be delivered by GP practices rather than a separate organisation (as detailed above in paragraph 75). In early discussions with NHSE, the BMA stated its strong preference for a national specification for the vaccination programme; NHSE then proposed in October 2020 a national ES specification to be issued to all practices (PB/806 - INQ000508140). NHSE also proposed that an IoS fee would be payable after completion of the second dose of vaccine, which was agreed with GPCE to be £12.58 per dose, £25.16 for the completed two-dose course.
98. In written comments on a draft COVID-19 Vaccination Programme 2020/21 Reference Guide sent by NHSE to GPCE on 3 November 2020, GPCE stated that linking payment of the IoS to the second dose of the vaccine risked causing cashflow problems for practices (PB/793 - INQ000505537). Nevertheless, GPCE voted between 4-5

November 2020 to accept the proposed indicative COVID-19 Vaccination Programme ES specification for General Practice (PB/676 - INQ000480981). Also in comments on the 3 November 2020 version of the draft COVID-19 Vaccination Programme 2020/21 Reference Guide, the BMA stated that additional funding would be needed for the vaccination of housebound patients due to the increased cost of this process compared to a walk-through clinic (PB/793 - INQ000505537).

99. On 15 November 2020, GPCE again raised concerns with NHSE regarding the payment of the loS fee following the second dose and the risk of cashflow issues for practices in comments on another draft of the ES specification, and proposed advanced payment on account at a suggested 70% of expected volumes (PB/678 - INQ000480983). Although NHSE agreed in principle to this (PB/683 - INQ000480989), this was ultimately not implemented by NHSE.

100. On 1 January 2021, a draft ES specification was received from NHSE with a proposed change to the payment schedule, stating that the loS fee was payable on completion of the administration for each of the first and then the second vaccine dose (i.e. £12.58 after the first dose and then £12.58 after the second dose) (PB/701 - INQ000481011).

Supplementary payments additional to the loS fee

101. Supplementary funding for delivering vaccines to those in older adult care homes was announced to PCNs and practices via a letter from NHSE on 13 January 2021 (PB/711 - INQ000329431). This additional funding included a £30 payment supplementary to the £12.58 loS fee for first doses administered Monday 14 December 2020 - Sunday 17 January 2021; a £20 supplement for first doses administered Monday 18 - Sunday 24 January 2021; and a £10 supplement for first doses administered Monday 25 - Sunday 31 January 2021 and for all second doses administered to all patients and staff who received their first dose on or before 31 January 2021.

102. GPCE, via email on 15 January 2021 to NHSE, requested the extension of the £30 rate of the supplementary payment per vaccine delivered in care homes for an additional week beyond 17 January 2021 due to many PCNs not having vaccine supplies during the week the payment was announced. NHSE initially stated this would

not be extended (PB/713 - INQ000481024), however the £10 supplementary payment was ultimately extended for all doses delivered in older adult care homes in February onwards as per a letter to LA Directors of Adult Social Care and ICS/STP Vaccination Leads from NHSE and DHSC dated 2 March 2021 (PB/802 - INQ000110789).

103. In line with GPCE's request in November 2020 for additional funding for vaccination of patients outside of vaccine clinics (see paragraph 98 above), a £10 additional payment for vaccination of housebound patients, back-dated to first vaccine doses delivered from 14 December 2020, was announced in a letter sent to PCN-led and community pharmacy-led local vaccination sites from NHSE on 4 February 2021 (PB/716 - INQ000329444). GPCE had been informed by NHSE the previous day that such funding was not confirmed and was not updated by NHSE directly when the availability of such funding was confirmed.

104. The £10 supplementary payment for vaccinations delivered in older adult care homes or to housebound patients was added to a draft update to the ES as detailed in a letter to GPCE from NHSE dated 24 June 2021 (PB/738 - INQ000481054). On 15 November 2021, a draft updated version of the ES was shared with GPCE for comment which included a further change to enable an additional £10 supplementary payment for third or booster dose vaccinations delivered to housebound patients between 16 September and 5 December 2021 (a £20 supplement for vaccinations to this group in total) (PB/803 - INQ000481099, PB/759 - INQ000481100). In response, the Chair of GPCE confirmed that this increase in payment was welcome.

Issues regarding payments to GP practices

105. On several occasions, GPCE, on behalf of GP practices, raised concerns to NHSE that practices had not received payment for vaccinations that they had delivered.

a. On 13 January 2021, GPCE raised that although the vaccination programme had started six weeks prior and 2.5 million vaccines delivered to patients, no payments had yet been made to practices for vaccine delivery (PB/712 - INQ000481023).

b. On 9 February 2021, the BMA raised concerns to NHSE regarding payment delays due to technical problems with the NHS Shared Business Services Manage Your Service portal, meaning there were

further delays to payments to practices for vaccinations (PB/720 - INQ000481032).

- c. GPCE again raised the issue of delayed payments for discussion at a meeting between NHSE and GPCE on 3 March 2021, noting some practices had reported they were still waiting for payments of up to £200,000 (PB/723 - INQ000481036).
- d. GPCE raised their concerns to NHSE again on 9 March 2021 in an email as the issue remained, and emphasised the negative impact this was having on practices. In response, NHSE apologised for the issue and detailed their measures to mitigate and resolve it (PB/726 - INQ000481041).

Omicron booster programme

106. Throughout September to November 2021, in the lead up to the Omicron booster programme, the BMA was engaging with NHSE and DHSC to address the increasing demand on general practice, rising workloads (including as a result of care backlogs and the transfer of significant amounts of the secondary care workload to general practice) and the abuse facing GPs and practice staff from members of the public due to a perceived lack of face to face appointments with GPs. This engagement followed comments from the former Secretary of State for Health which suggested the UK was “almost back to completely normal” - when clearly this was not the case - and that GPs should be offering more face-to-face appointments (PB/644 - INQ000479110) prompting the BMA to write to the Government in September 2021 requesting an urgent meeting so that GPs could be properly supported to manage workloads (PB/234 - INQ000097914).

107. This letter highlighted that “...*there are simply too few GPs and practice staff in under resourced premises to meet the huge surge in demand that practices are currently experiencing, which will be exacerbated by the Covid vaccination booster programme...it will be GPs and their practice teams who will be leading this additional work. Given the magnitude of delivering millions of vaccines over the coming months, together with increased patient demand during the winter, it is vital that the public are made fully aware of just how much strain practices are under and how the service may*

have to change in order to manage, what is in effect an unmanageable workload. We are not “back to completely normal” and it is wholly unrealistic to suggest that practice(s) can, under current conditions, return to pre-pandemic ways of working”.

108. On 30 November 2021, the Government announced that a COVID-19 booster vaccine would be offered to all eligible adults by the end of January 2022. The Government announced that payments to GP practices would be increased to £15 for every vaccine delivered, with an additional £5 for vaccinations on Sundays and bank holidays. A supplementary payment of £30 was confirmed for each vaccine administered to housebound patients.
109. The BMA’s view was that while the funding was welcomed, it would do little to help alleviate current pressures in light of workforce shortages, patient demand, time, and capacity. This position is set out in a media briefing document dated 1 December 2021 (PB/788 - INQ000098584). While in the first phase of vaccinations practices were told to deprioritise some routine work, such as some health checks or other more administrative activity to focus on the vaccination campaign, this was no longer the case. Practices were now being told to return to pre-pandemic levels of ‘routine’ activity and only take part in the booster campaign if they could manage to do both.
110. On 3 December 2021 the GPCE chair met with NHSE and DHSC regarding the expansion of the COVID-19 vaccination programme to rapidly deliver boosters with the aim of slowing the spread of the Omicron COVID-19 variant (PB/762 - INQ000481104).
111. A letter from NHSE to ICS (Integrated Care Systems) and STP (Sustainability and Transformation Partnership) Leaders circulated on 3 December 2021 highlighted changes to increase capacity in PCNs to deliver vaccines while protecting practice income, including through amendments to the QOF (Quality and Outcomes Framework) which protected income in some areas, reduced requirements for some prescribing reviews, permitted health checks for over 75s to be deferred, and suspended most IIF (Investment and Impact Fund) indicators (except those covering flu immunisations and some other completed work) (PB/761 – INQ000329557). The letter also confirmed the financial changes previously announced on 30 November that the IoS fee would be increased to **I&S** for every vaccine delivered weekdays and Saturdays, or **I&S** for vaccines delivered on Sundays and bank holidays, between 1

December 2021 and 31 January 2022, as well as the temporary increase to the supplementary payment to I&S for booster vaccinations to housebound patients until 31 December 2021, backdated for those already carried out. A temporary I&S supplement per vaccine administered to patients identified as severely immunosuppressed between 1 December 2021 to 31 January 2022 was also announced at this time. The I&S Sunday and bank holiday IoS payment was later extended to all vaccinations administered during the period 25 December 2021 to 3 January 2022 inclusive.

112. Between 6 and 7 December 2021 GPCE and NHSE worked jointly (PB/765 - INQ000481108, PB/764 - INQ000329558) on a letter to GP practices and PCNs detailing the temporary GP contract changes to support the COVID-19 vaccination programme, including the reallocation of points in the QOF, and new and suspended IIF indicators (PB/763 - INQ000481106).
113. GPCE continued to meet with NHSE during December 2021, and were involved in updating the ES specification schedule (PB/769 - INQ000481114). The supplementary payment of I&S for vaccines delivered to severely immunosuppressed people was extended in January 2022, to 31 March 2022 (PB/775 - INQ000481122).
114. The BMA is aware of, and firmly disputes, allegations made by the former Secretary of State for Health and Social Care, Sir Sajid Javid, at paragraphs 141 and 142 of his Module 4 witness statement (INQ000474381), in which he accuses the BMA leadership of not acting in the national interest during the Omicron crisis, and states the BMA was taking commercial advantage by putting the interests of its members above delivering the vaccination scheme. The former Secretary of State's characterisation of the BMA's role in respect of the Omicron booster programme is factually inaccurate and wholly unfair. The BMA's role and responsibility as a trade union required its leadership to negotiate payment rates for vaccinations to enable GP practices to deliver vaccinations on top of routine services. Our approach as a trade union is to support doctors so that they can provide the best service possible to patients. As highlighted above, general practice was already at breaking point, with too few GPs and staff doing their best to manage unmanageable workloads. The BMA welcomed additional funding being made available but remained concerned about the high workload and lack of workforce capacity within general practice. There was some

reduction to requirements and deferral of services announced in December 2021, but it was not the case that GPs “were not doing additional work” or that they could “simply reprioritis[e] their time”. The booster vaccination programme was new and additional work, requiring existing or additional staff to take on additional hours, often at weekends. Enhanced payment rates to help cover these extra costs for the booster vaccinations were agreed with NHSE in recognition of the resource implications of delivering mass vaccinations in general practice and the BMA rejects that this amounted to GP practices being paid twice as alleged. Indeed, the efficiency with which GPs delivered the mass vaccination programme was more cost effective than the cost per vaccination in mass vaccination centres (INQ000065228).

After the Omicron booster programme

115. GPCE met with NHSE on 19 May 2022, where GPCE raised concerns that the funding arrangements in the Draft Enhanced Service Specification September 2022 to 31 March 2023 (phase 5) COVID-19 vaccination programme (PB/784 - INQ000481135) were inadequate due to a reduction to the IoS fee to £10.06 (previously £12.58, other than the period during the December 2021 booster vaccine campaign when the IoS fee was increased to **I&S** or **I&S** as detailed above) per vaccination (PB/785 - INQ000481136).
116. NHSE confirmed £10 supplements for vaccinating housebound patients would continue, however NHSE also indicated it was unlikely that they would be able to increase the financial envelope. GPCE reiterated their concerns regarding funding for this stage of the programme to NHSE by email (PB/786 - INQ000481137).
117. As no agreement was ultimately reached between GPCE and NHSE on the financial arrangements for the ES at the time of publication, GPCE did not agree to the inclusion of the statement “This ES has been agreed between NHS England and the British Medical Association (BMA) General Practitioners Committee (GPC) in England” within the Enhanced Service Specification September 2022 to 31 March 2023 (phase 5) - this represented a departure from previous processes as the above statement had been included within all previous versions of the ES specification (PB/787 - INQ000481139).

Wales

118. The collaboration between Welsh practices under the Primary Care Contract Services: Immunisations (PCCS:I) and the strategic variation between areas was instrumental in maintaining both flexibility and thorough coverage across different population cohorts. Of the approximately 14 million vaccines administered by general medical services practices, over half were conducted between April and September 2021. This meant that half of the extra income associated with the prioritised drive was attributed to the 2021/22 financial year.

119. The funding arrangements outlined in the PCCS:I (PB/658 - INQ000479124) stipulated that:

The Local Health Board must pay to an engaged provider who qualifies for the payment in accordance with Directions 5 to 7, a payment of—

(i) £12.58 in respect of each dose of a COVID-19 vaccine administered to a person under this PCCS:I, and

(ii) £400 for every 1,000 vaccines administered under this PCCS:I.

Scotland

120. In Scotland, as health boards were responsible for the vaccination programme, the BMA negotiated the payment arrangements to be made under the DES to participating practices. These arrangements were set out in Annex A to NHS Circular: COVID-19 Vaccination Direct Enhanced Service 26 November 2020 (PB/685 - INQ000480991) as follows:

- a. The Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2018 were amended to include the COVID-19 Vaccination Programme. The 2018 Directions moved vaccinations out of the GP contract to health boards.
- b. GP contractors who have entered into an arrangement with a Health Board as part of that Health Board's COVID-19 Vaccination Programme will be reimbursed in accordance with the paragraph below.

- i. A flat rate of £12.58 will be paid per dose totalling £25.16 per course. It is not necessary for a practice to provide both doses of a course to receive payment.
- ii. All contractors whether or not they have entered into an agreement with a Health Board as part of that Health Board's COVID-19 Vaccination Programme will be paid £40 for every hundred patient records updated by the practice for vaccinations not carried out by the practice. This should be rounded to the nearest hundred patient records.
- iii. Prior to issuing payments in accordance with the above, Health Boards must require contractors who have entered into an arrangement with a Health Board's COVID-19 Vaccination Programme in terms of the DES Directions 2018 as amended to sign a declaration to confirm that they are meeting the requirements of the DES Directions 2018.

Northern Ireland

121. In Northern Ireland a Local Enhanced Service (PB/733 - INQ000481048) was devised by the Health and Social Care Board to set out the specification of the COVID-19 vaccination service for GPs. Fee levels were:

- a. £12.58 per vaccine administered to all relevant patients (including those vaccinated at GP request by district nursing teams and any vaccinated by Public Health Agency vaccinators as part of GP vaccination clinic).
- b. Additional support money in recognition of the challenges of social distancing, need for staff training, data collection and possible indemnity costs, based on practice populations. The total for each practice was £400 per 1,000 patients on practice list per round of vaccinations (1st and 2nd doses).
- c. Further additional support money was to recognise the challenges relating to vaccine supply to date and on the basis that practices will use

the Vaccinations Management System (VMS). This was based on practice populations. The total for each practice was an additional £100 per 1,000 patients on practice list per round of vaccinations (1st and 2nd doses).

The BMA sought to ensure efficiency and minimise cost and wastage

122. As discussed in Section D, GPs and their teams were delivering vaccines alongside non-COVID and COVID care. In terms of efficiency and minimising cost and wastage, the role of BMA members was to follow the available guidance and administer vaccines as quickly as possible (including evenings and weekends as well as daytime sessions) – and the success of the vaccination programme demonstrates that they made every effort to do so. BMA members reprioritised workloads to ensure a swift rollout and reported wastage where it arose.

Vaccine wastage

123. The BMA called for the avoidance of vaccine wastage to enable more people to be vaccinated sooner (PB/704 – INQ000300347).

124. There were two main issues driving concerns over vaccine wastage. First, it was sometimes possible to get an extra dose from the multi-dose vial but there weren't people booked in to give it to. The second was additional doses left over at the end of the session and GPs were instructed not to give vaccines to people outside the initial eligible groups; from mid-January 2021 the "golden rule" was stated by NHSE not to waste a dose and more flexibility about giving these doses to those who were unvaccinated was made possible.

125. In a letter to the National Medical Director in England dated 25 January 2021 (PB/291 - INQ000400481), the BMA raised concerns about wastage that had been communicated in previous discussions between the UK consultants committee chair and NHSE's National Medical Director. The letter was prompted by reports from BMA members that some doses may have had to be discarded if other first-dose appointments could not be arranged in time, rather than give a second dose to an

available member of healthcare staff or other frontline workers such as police and schoolteachers. This was in line with national policy at the time, which stated that Trusts would be audited on any second vaccine doses they provided to ensure that no doses were administered prior to the 12-week interval decreed centrally rather than the 8-week interval stated in the vaccine summary of product characteristics of the vaccine license.

126. To better understand the scale of the issue identified with vaccine wastage and to verify reports of wastage, the BMA opened an online portal where members could share their concerns and experiences. Members reported widely that vaccine doses were being discarded rather than being administered to staff, other frontline workers or patients, given the policy about dosage intervals. The portal had received 93 entries by 23 February 2021. Some examples of member responses via the portal include:

- “We are being made to discard doses from a vial rather than give second doses to those that could otherwise have them.”
- “Clinics are being threatened with closure if they give second doses to staff (who were consented for two doses) and are being forced to bin vaccine rather than put it in people's arms.”
- “Staff being told spare vaccine doses available and would be wasted but refused to staff as second dose. This has been experienced by ICU nurses and Consultants at our Trust.”

Vaccine booking systems

England

127. The involvement of BMA members in the design and maintenance of COVID-19 vaccination booking and data recording systems in England was sporadic. While the BMA, RCGP, NHSE, and their relevant contractors eventually agreed upon a regular forum (a 1-hour meeting every Wednesday 5-6pm for a period of nearly two years for discussion and feedback of issues), the BMA was not invited to advise on the initial design of the system until some of the foundational aspects had been decided upon –

namely that Pinnacle would be used as the point of care clinical information system for recording vaccinations.

128. The decision to adopt Pinnacle as the point of care system was controversial. At the time, Pinnacle was widely used within the pharmacy sector to record vaccination delivery, however it was generally not used within general practice by GPs, with GPs overwhelmingly favouring EMIS and TPP as core clinical information systems. With the bulk of the UK's initial vaccination drive expected to be delivered by GPs, the decision to impose upon them a system that was a) unfamiliar to them and b) not immediately and easily interoperable with existing GP IT systems (EMIS and TPP) was puzzling. The main concern about Pinnacle was that it took a lot longer to input the information into the system rather than using the practice system. This added workload as well as delayed the information appearing in those records. It was and remains the BMA's view that this decision created undue complexity and stress for GPs in delivering the vaccine during the initial rollout. Compounding this were technical challenges presented by widespread use of the software. The elements described above conspired to hinder the informational aspect of vaccine delivery, with some GPs resorting to recording information on paper or in Excel for subsequent input into native GP IT systems.

129. In addition to information governance issues, the adoption of Pinnacle led to challenges for GP practices to properly code payment information. As independent organisations holding a contract with NHSE to provide services, it was, and is, critical to the ongoing provision of primary care that GP practices are remunerated for non-contractual services. Prompt remuneration is vital to enable practices to cover the significant additional costs incurred in delivering the vaccination programme, while also allowing the continued functioning and provision of those services stipulated by their contract. It should be noted that at no point did these payment issues stop practices from delivering vaccines.

130. In November 2020, the BMA wrote a joint letter from the BMA/RCGP Joint GP IT Committee to the Director of the COVID-19 Vaccination programme, to clarify why there was no consultation on the IT system for the vaccination programme (PB/287 - INQ000400428). The letter outlined feedback with a number of concerns about the choice of system from members of both organisations, such as issues with the

appointment booking process, recording payment information, and exception reporting. In response, a series of meetings were established between BMA, RCGP, NHSD and consultants contracted to oversee the point of care IT infrastructure. These provided a regular and direct channel to feedback issues reported to GPCE by GPs and to troubleshoot and anticipate any potential issues at each stage in the rollout. Ultimately, due to the pressing need to ensure safe and successful rollout, the discussions were more solutions-focused rather than dwelling on why BMA/RCGP had not been consulted earlier.

Wales

131. The Welsh Immunisation System (WIS) was developed by NHS Wales Informatics Service (NWIS) in Autumn 2020 as a central system for the management and administration of immunisations - specifically COVID-19 immunisations in the first instance. WIS exists in 'web' and 'core' formats, with the former intended for real-time usage during vaccination sessions and the latter for administrative purposes.
132. PCCS:I directions required the usage of WIS for GP practices undertaking COVID-19 immunisations - for recording consent, contraindications, adverse events, and the vaccine delivered. Practices were able to use their own call and recall mechanisms for their patients. WIS would be the basis for payment under the PCCS:I for vaccines delivered.
133. Automatic write-back to GP clinical systems was agreed during the development of WIS although not immediately available. The BMA's General Practitioners Committee for Wales (GPCW) advised practices and LMCs that practices undertaking COVID-19 vaccinations should keep their own record of immunisations - ensuring appropriate clinical record keeping and for payment purposes. This required a large increase in GP administrative time spent entering data, which was costly.
134. On 05 February 2021 Welsh Government officials shared a letter with GPCW (PB/719 - INQ000481031) aimed at practices which encouraged entry into WIS in real-time or as soon as possible prior to the end of day of the vaccination administration. GPCW responded (also 05 February 21) to raise concerns with the WIS system

including the lack of writeback and financial claiming mechanism (PB/717 - INQ000481029).

135. On 02 March 2021, the Vice Chair of GPCW wrote to the NWIS Medical Director (PB/722 - INQ000481035) raising concerns at the lack of write-back to GP systems from WIS and the lack of GPCW involvement in the plans for a bulk overwrite into GP systems which would remove Read Codes and free text input by GPs themselves. GPCW outlined that this created critical clinical governance issues and potentially destabilised the claim/payment process.

136. NWIS responded on 05 March 2021 (PB/724 - INQ000481039) acknowledging concerns citing their ask to GP system suppliers to cease mass overwrite plans and proposing that NWIS and GPCW maintain ongoing dialogue and representation on various groups. GPCW responded on 10 March 2021 (PB/727 - INQ000481042) accepting the offer of future discussions.

137. Issues regarding 'write back' to the GP record took some time to resolve but overall practices were able to use WIS for the purposes of administering and claiming for COVID-19 vaccinations delivered.

Scotland

138. In Scotland, vaccine bookings were initially done via TURAS (NHS Education for Scotland's single, unified platform). This was later moved onto a bespoke platform for vaccine bookings. The BMA was not closely involved in the development of these systems.

Northern Ireland

139. The BMA was not closely involved with the development of the vaccine booking system in Northern Ireland. Initially vaccines were recorded in GP patient records. This was then changed to recording in a Vaccine Management System.

Data collection, handling and record keeping

140. For the duration of the pandemic, GP data in England and Wales were subject to Control of Patient Information (COPI) notices. Access to GP data is subject to a number of checks and balances. These are put in place to preserve the integrity of the doctor-patient trust relationship and to ensure that GPs uphold their obligations as data controllers under GDPR. This issuance of COPI notices by the SoS was intended to support the UK's pandemic response by lowering the threshold on who can access GP data, what they can access and what reason is needed to use those data. The BMA was broadly supportive of these measures and recognised the importance of making GP data available for COVID-19 research and planning. These notices have since been withdrawn - many of them over the course of 2022 - with access to GP data once again subject to appropriate checks and balances to protect patients.

141. Whilst the BMA had a voice in the decision to implement COPI notices - by way of email and MS Teams discussions as well as formal Joint GP IT Committee meetings between the BMA, RCGP and NHSE/DHSC in which approval was sought - once in place our members did not have a choice about whether or not they shared data, as the COPI essentially placed a legal obligation on them to share. The way in which GP data flow in and out of practices (in England) (both pre, during and post COVID) is as follows:

- Patient > Practice > GPES (General Practice Extraction Service, NHSD [now NHSE]) > Third parties

142. Therefore, in the vast majority of cases, practices operating under instruction by a COPI are required to share any enhanced level data with NHSE/D who in turn take responsibility under GDPR regulations for any onward dissemination.

143. During the pandemic, almost all data extracted from GPs flowed through NHSE's COVID-19 Data Store. The COVID-19 Data Store was established by NHSE early on in the pandemic. The BMA raised concerns about the handling of patient data at the time, these included the absence of a procurement exercise, choice of vendor and lack of transparency about how data were being processed by NHSE and by contractors on behalf of NHSE (PB/607 - INQ000479073). There remain outstanding concerns about the extent of third-party contractors' involvement in handling patient data.

Use of GP records

England

144. GP records were used extensively in the identification of, and communication with, vulnerable individuals in relation to both vaccination and therapeutics. This took place through the following programmes/frameworks and (for the most part) under direction from the SoS for Health and Social Care.

- Shielded Patient List (SPL) - The SPL comprised a list of all patients deemed vulnerable and advised to shield at home. The list drew on GP data and was used by patients to verify their status through a government online portal, the verification from this portal was subsequently then used to provide verification to third parties, including online supermarkets. This ensured that although GP data were used, they were not disseminated any further than necessary.
- COVID-19 risk assessment – This programme estimated a person's combined risk of contracting COVID-19 and being admitted to hospital. It drew on GP data and was used to identify additional persons for inclusion on the SPL as well as persons to receive priority vaccination.
- COVID-19 vaccination call and recall booking systems – This was the tool used by vaccine providers to identify individuals and offer vaccines. It relied on a range of databases and programmes to function, with patients variously identified at practice, PCN and national levels as eligible to receive vaccines. In all cases, GP data were integral to the functioning of this process.

145. The data used to underpin these programmes came from a range of channels, some of which have been discussed above.

146. Where GPs and their teams led the first wave(s) of vaccinations targeting priority groups – the same practice as is applied in routine vaccinations drives was applied - chiefly, the implementation of the call/recall system. This meant that although identifiable patient information was used in the identification of vulnerable individuals, those who indicated that they did not wish to receive the vaccine would have all communication ceased. Those contacted who did not reply would receive

communication via any other contact methods listed within their records including post, email, SMS and phone call.

147. With a heightened level of cooperation between the BMA, NHSE and DHSC – primarily via the BMA and RCGPs Joint GP IT Committee at both formal and informal meetings at the outset of the pandemic, it is the view of the BMA that GP data were used for direct care effectively for most of the pandemic.

148. The public discourse around how their data are handled changed significantly over the course of the pandemic – with the population at large growing more comfortable with their data being used to track COVID-19 infections, validity of COVID-19 vaccines for travel and via a slew of different research programmes developed independently of NHS organisations, including the ZOE health study, for example. In conjunction with this, greater awareness of the benefits of using data emerged as a key driver of patient confidence in the NHS. This brought with it a greater degree of concern around how data can be misused, culminating in mass opt-outs in response to the governments planned General Practice Data for Planning and Research (GPDPR) programme.

Devolved nations

149. In the devolved nations, GP data were used primarily in the identification of shielding patients. For example, GPs in Wales would have supported Digital Health and Care Wales to ensure shielded patient list data were accurate. In Scotland, GP practices have a requirement to cooperate with health board provision of services and BMA Scotland would have encouraged them to do so to support the vaccination programme.

Prioritisation and eligibility for vaccination

The BMA agreed with JCVI's recommended prioritisation and eligibility list within the wider population

150. COVID-19 vaccination was central to the pandemic response. On 8 December 2020, the UK became the first Western country to license a COVID-19 vaccine. The Pfizer-BioNTech vaccine was authorised for emergency use, marking a pivotal

moment in the countermeasures against the pandemic. On 30 December 2020, the Oxford AstraZeneca vaccine received its first approval for use in the UK vaccination programme. The Moderna vaccine was the third COVID-19 vaccine gaining approval in January 2021.

151. On 2 December 2020, the JCVI released official priority groups for COVID-19 vaccination (PB/611 - INQ000479077). The JCVI stated that the recommended age-based programme would likely result in faster delivery and better uptake in those at the highest risk.

152. When the JCVI's final prioritisation list was released, the BMA released a statement from the BMA UK council chair (PB/612 - INQ000479078), who said the COVID-19 vaccine was *"an incredible achievement of modern science"* and that it would *"finally start to bring the pandemic to an end."* However, he caveated that the UK had *"never tried to deliver a vaccination programme of this size, and at this speed, ever and there are many practical hurdles to consider and overcome. The first wave had a severe impact for people of Asian backgrounds - in terms of admissions to intensive care units, and high death rates. Today's guidance from the JCVI – to prioritise patients in accordance with the risk, those from an older age, and with underlying conditions, also seeks to address inequalities affecting some populations, including those from BAME backgrounds."*

153. The BMA UK council chair stressed that the key to its success would be getting as many people vaccinated as possible and that this would need the support of local community leaders, local public health staff as well as the work of those medically trained. *"It's important for members of the Asian community at higher risk to be inoculated, to protect themselves, family members and their wider community. But they must feel confident and well informed to do this and this means good public health messaging through the right channels - trusted and owned by local communities, and ideally delivered together with community leaders."*

The BMA's view was that the most vulnerable and frontline healthcare workers should be prioritised for vaccination

154. The BMA's view was that those most at risk of illness or death from a COVID-19 infection and frontline healthcare workers should be prioritised for vaccination. Frontline health (and social) care workers had a far greater risk of exposure due to their work caring directly and intimately for patients with COVID-19 (PB/603 - INQ000271363). Because health services were already operating with severe workforce shortages, it was imperative that doctors and other frontline staff be protected so they could continue providing services.
155. In response to the approval of the Oxford AstraZeneca vaccine by the Medicines and Healthcare products Regulatory Agency (MHRA), the BMA published a media release on the 30 December 2020, which called for urgent action to accelerate vaccine delivery. BMA UK council chair at that time, emphasised the importance of swiftly distributing the vaccine to GP practice sites and hospital hubs. The goal was to begin mass vaccination as soon as possible, especially targeting those most at risk should they contract the virus and frontline healthcare workers. While the Oxford-AstraZeneca vaccine posed fewer logistical challenges than the Pfizer vaccine, the task of vaccinating large numbers of patients and staff in a short time frame remained a significant challenge. The BMA stressed the need for support, investment, and flexibility for doctors involved in the rollout. Vaccination, we asserted, would play a decisive role in controlling the pandemic, but until widespread uptake occurred, adherence to restrictions and infection control measures remained crucial and still remains relevant to this day (PB/616 - INQ000479082).
156. However, despite the launch of the vaccination program with two approved vaccines, there was variation in the way some Trusts operated. For example, not all had adequate cold storage facilities for the Pfizer vaccine. There were also limitations in terms of vaccine availability i.e., vaccinating healthcare workers at the same time as providing vaccinations to those over 80 years of age. This resulted in inconsistent delivery across sites.
157. The BMA further emphasised prioritisation for healthcare workers in a briefing on 7 January 2021 (PB/703 - INQ000098606). The BMA stated that frontline healthcare workers must be vaccinated as soon as possible. This was essential not just to protect

those individuals who are most likely to be exposed to the virus, but also to stop the NHS being overwhelmed. The BMA called for vaccination of healthcare workers to be significantly accelerated, with an aim for all healthcare workers to have received their first vaccination no later than the end of January and those at greatest risk by the 20 January 2021.

158. A letter from the BMA addressed to all Chief Executive Officers of NHS Trusts in England on 7 January 2021, highlighted urgent concerns regarding the COVID-19 vaccination and the protection of staff (PB/704 - INQ000300347). It emphasised the need for priority vaccination of healthcare workers due to their much higher risk of exposure to the virus. The letter urged Trust CEOs to ensure that all healthcare workers at risk of exposure to COVID-19 through their work receive their first vaccine dose by the end of January with those at highest risk being vaccinated within two weeks and called for prompt administration of the second dose. It also emphasised the importance of avoiding vaccine wastage (which is discussed at paragraphs 122 to 1266 above) and prioritising those most at risk.

159. A BMA news article published on 8 January 2021 also emphasised the need to prioritise frontline vaccination (PB/623 - INQ000479089). The BMA UK council chair urged the government to prioritise vaccination for frontline staff to protect the workforce and prevent the NHS from becoming overwhelmed.

Concerns about the AstraZeneca vaccine

160. In March 2021, several countries officially announced that they were temporarily suspending the use of the AstraZeneca vaccine against COVID-19 after concerns about potential side effects in the form of spontaneous blood clots. While acknowledging concerns, the BMA underscored the importance of vaccination in the fight against COVID-19. In a BMA news article published on 16 March 2021, the co-chair of the BMA's public health medicine committee at that time, said

"the UK's vaccination program has been highly successful, with over 11 million doses of the Oxford AstraZeneca vaccine administered, contributing significantly to public health and the return to normalcy. Despite concerns raised by some European countries, regulatory agencies like the MHRA,

WHO, and EMA continue to endorse the safety of the AstraZeneca vaccine. Encouraging people to receive both doses of the AstraZeneca and Pfizer vaccines is crucial for saving lives. It's important to maintain perspective on the severity of the pandemic while recognizing the life-saving impact of vaccination.” (PB/630 - INQ000479096)

161. The BMA issued a press release on 7 May 2021 responding to the recommendation from the JCVI to offer people under 40 years old an alternative to the AstraZeneca COVID-19 vaccine. The BMA UK council chair emphasised that blood clots specifically linked to the AstraZeneca vaccine were rare, and that the benefit of the vaccine outweighed the risk for most people. He noted that the UK was in a good position to have access to different vaccines and thus it was crucial that the vaccines were easily available. To avoid confusion and requests for specific vaccines, he suggested that vaccination sites needed advanced notice of which vaccine they were receiving so that booking systems could direct individuals to the site with the correct vaccine, e.g. whether they are under 40 or pregnant or planning to become pregnant. The medical staff at the vaccination site needed updated guidance to communicate effectively with patients about the decision. Finally, he emphasised the need for clear communication to maintain vaccine confidence (PB/634 - INQ000479100).

Reporting adverse reactions

162. There was a pre-existing mechanism – the Medicine and Healthcare products Regulatory Agency (MHRA) Yellow Card Scheme – for the reporting of adverse reactions to medicines, including vaccines, which can be used by patients as well as clinicians. The MHRA set up a dedicated Yellow Card portal for coronavirus. This was to be used for reporting suspected side effects to medicines, vaccines, medical device and test kit incidents used in coronavirus testing and treatment.

163. Where the BMA received inquiries about adverse reporting, it would have been usual practice to refer people to the Yellow Card scheme and encourage reporting via that route. For General Practitioners in England, it is usual for the vaccination specifications, including for Covid-19, to include a section on monitoring and reporting covering the recording of adverse events, providing patients with information on the process to follow if they experience an adverse event after leaving the vaccination site,

including signposting to the Yellow Card scheme. This information may vary slightly depending on the nature of the vaccine and the likelihood of adverse incidents occurring. Any changes to this scheme or reporting requirements would need to be carefully considered.

Dosing intervals for the Pfizer vaccine

The BMA had concerns about changes to the dosing interval of the Pfizer vaccine

164. The BMA in all four nations raised member concerns with changes made to the dosing interval between the first and second dose of the Pfizer vaccine, which were not at the time supported by the manufacturer themselves and caused significant concern and anxiety to healthcare staff. A key reason for the delay between doses was inadequate vaccine supply.
165. The initial rollout of the Pfizer vaccine required two doses, with the second to be administered within 21 days of the first. In a joint statement also authorising the deployment of the AstraZeneca/Oxford vaccine on 30 December 2020, all four Chief Medical Officers confirmed their agreement with the MHRA and JCVI advice that first doses of vaccines would be prioritised for as many people as possible (M2B/PB/006 - INQ000355911). Operationally, this meant that second doses of both vaccines would be given within 12 weeks rather than within Pfizer's initially advised timescale of 21 days. At this point many BMA members and many other frontline health and care staff had already received their first dose of the Pfizer vaccine. Many of the most elderly patients had also received their first dose and by this time had been given an appointment for the second dose in January.
166. While the BMA appreciated the broad aim to protect the largest number of individuals and reduce the pressures on the NHS, the BMA's considered stance was this should only be achieved within the licenses and usage specification of the vaccine as it stood at the time. The publicly available data from the Pfizer vaccine trial had covered second doses only up to six weeks; therefore, it was unknown at that time whether a longer interval would compromise immunity and it was against Pfizer's own recommendation. Given that healthcare workers already felt pressurised to maintain care in the presence of inadequate PPE, and outdated NHS estates that made it hard

to isolate or distance patients and staff appropriately or provide effective levels of ventilation, the sense that they were further unprotected and being put in harms' way by government decisions was voiced repeatedly.

167. BMA members (and other health and care workers) were far more likely to be exposed to high levels of the virus and therefore infected in the course of their daily duties compared to the general population (PB/603 - INQ000271363). Member feedback received at the time indicated that the decision had been extremely damaging to morale and wellbeing, and staff confidence in the vaccination regime itself.

168. The BMA was also concerned about the impact of this change on patients. In a press release dated 31 December 2020 (PB/618 - INQ000479084), the BMA stated that asking GP practices to rebook appointments of tens of thousands of elderly and vulnerable patients, who were due to get the second dose of their vaccination in a few days' time, was unreasonable and unfair, and practices who honoured existing appointments booked for the next few days should be supported. GPs and clinical leaders told the BMA that the cancellation of appointments would have a 'terrible' impact on the emotional well-being of their most vulnerable, at-risk patients. The BMA stated that patients that had received their first vaccine and had been told by the NHS and local clinicians that they would receive the second dose of Pfizer vaccination within the original dosing interval of three weeks had given their consent to vaccination on that basis and therefore had an expectation they would be vaccinated in line with that timeframe. This is also considered above in sub-paragraph 78.a.iv.

Concerns raised at an England and UK level

169. The BMA engaged with Government and NHS bodies in England on this issue primarily through formal letters and meetings:

England and UK level

- a. 31 December 2020 – The BMA UK Consultants Committee Chair, UK Junior Doctors Committee (now UK Resident Doctors Committee) Chair, UK Staff, Associate Specialists and Specialty Doctors Committee Chair and UK Medical Academic Staff Committee Chair wrote to all Trust Chief

Executives in England informing them of the BMA's position that all healthcare workers must receive the second dose as soon as they are eligible, rather than being made to wait 12 weeks (PB/440 - INQ000400433).

- b. 4 January 2021 – The BMA Chair of Council wrote to Professor Chris Whitty expressing concern about the delayed second dose of the Pfizer vaccine as data were only available for a 42-day dosing interval, and the manufacturer had not supported its use beyond the recommended regime (PB/271 - INQ000400438).
- c. 5 January 2021 – The BMA Chair of Council met with Professor Chris Whitty (PB/441 - INQ000400440) to reiterate the BMA's concerns, but these concerns were not accepted by the CMO. Limited vaccine supply was also discussed. Subsequently, on 11 January 2021, NHSE and NHS Improvement issued an instruction on the timing of second doses of COVID-19 vaccinations (PB/707 - INQ000329430). The instruction meant that “all appointments to receive the second dose must be rescheduled, with recipients to be booked in for a second dose in the 12th week. This includes second dose arrangements for both patients and health and care staff...”.
- d. 22 January 2021 - BMA Chair of Council wrote to Professor Chris Whitty about growing concern within the medical profession citing WHO analysis suggesting it should be given within 21-28 days or as soon as possible thereafter (M2B/PB/112 - INQ000118678).
- e. The BMA had also raised concerns at the time about whether in following JCVI and CMO advice to change the scheduling of the second dose of the Pfizer vaccine, there would be a risk to an individual doctor's registration and license to practice:
 - i. 7 January 2021 – The GPCE Chair wrote to the GMC Medical Director and Director of Education and Standards, outlining the BMA's concerns about the changes to the Pfizer dosing interval and asking the GMC to provide assurance that they would

support GPs and their teams if they chose to administer the Pfizer vaccination to patients according to the current guidance issued by the JCVI and the four CMOs, despite this being outside of the manufacturer's instructions (PB/308 - INQ000400511)

- ii. 13 January 2021 – The GMC Medical Director and Director of Education and Standards responded to the GPCE Chair acknowledging the pressures that doctors were facing and stating that it was highly unlikely that administering the Pfizer vaccination in line with the JCVI and CMO guidance would raise any fitness to practice concerns (PB/710 - INQ000400467).
- f. The BMA also engaged with NHSE via the Social Partnership Forum to consider the issue of the interval delay with regards to the Pfizer vaccine:
- i. 12 January 2021 - the issue of the second Pfizer dose delay was discussed at the SPF COVID Engagement Group which was attended by representatives from NHSE. The BMA's head of public health and healthcare attended.
 - ii. 20 January 2021 - the SPF held a vaccination workshop with its members. The workshop was attended by representatives from NHSE and the Chair of the JCVI (Joint Committee on Vaccination and Immunisation). The BMA's head of public health and healthcare attended. Among the specific issues discussed were whether vaccines could be mixed and matched and whether those in higher risk groups should be given their second dose earlier than 12 weeks.

Concerns raised at a Devolved Nation level

Northern Ireland

170. BMA Northern Ireland expressed strong views objecting to the increased interval between the first and second doses of the Pfizer vaccine, to the CMO from Northern

Ireland (PB/325 – INQ000400519), in writing to the Minister on 2 January 2021 (PB/92 - INQ000116898), in an urgent meeting and in the media. This was a particular concern for doctors in Northern Ireland as care home residents and staff working in care homes were receiving the second Pfizer dose at a three-week interval, while a doctor who was seeing patients in these care homes had a 12-week interval between doses (PB/700 - INQ000276527).

Scotland

171. BMA Scotland's significant concerns were communicated to the CMO and Deputy CMO for Scotland via email on 02 January 2021 (PB/442 – INQ000400437) as well as in a meeting of the Workforce Senior Leadership Group. BMA Scotland also raised this issue through the media – most significantly during early January 2021, when, Chair of Council for Scotland at the time referred to concerns during media interviews and quotes provided to the media.

Wales

172. BMA Cymru Wales' significant concerns were conveyed in communication with the Chief Medical Officer, the Minister for Health and Social Services and the Chief Executives of Health Boards during January 2021 and BMA Cymru Wales also commented on this decision via the media (e.g. M2B/PB/007 - INQ000355929).

- a. 04 January 2021 – The Chair of Welsh Council and the National Director for Wales met with the CMO raising concerns about the delay in the Pfizer vaccination dosing interval. After the meeting the National Director for Wales circulated an internal note (M2B/PB/117 - INQ000355930).
- b. BMA Cymru Wales met with and wrote to the Minister on 8 January 2021 putting forward proposals for a way forward within the licenses of the vaccines deployed (PB/351 - INQ000118674). These proposals included accelerated access to the second Pfizer dose for healthcare professionals (particularly those at highest risk) in line with extant data and guidance, and inclusion of the recently approved AZ vaccination for

those staff who were yet to receive their first dose. In this letter, BMA Cymru Wales also called for transparency of data around rollout and vaccine availability to provide greater assurance to members, and all healthcare professionals, about the expected availability of both vaccines and the anticipated timelines for staff to receive their first and second doses.

- c. A joint letter to all Health Board Chief Executives was sent by the Chairs of all BMA Cymru Wales branch of practice committees on 12 January 2021 (see for example M2B/PB/165 - INQ000355938). This letter relayed member concerns about changes to the Pfizer vaccination dosing interval. The letter asked that, to ensure maximum protection, second doses of Pfizer be administered within 42 days (in line with the trial data) to healthcare workers who had already received their first dose, and that the AZ/Oxford vaccine be incorporated within the vaccination programme for staff. It also asked for a copy of the Health Board's vaccination schedule to increase transparency. BMA Cymru Wales received a reply from the Cardiff and Vale University Health Board on 18 January 2021 stating that they would administer the second Pfizer dose within 12 weeks (M2B/PB/166 - INQ000355939). To the best of my knowledge, written responses were not received from other Health Boards.
- d. 22 January 2021 – Email from the National Director of BMA Wales and the Chair of Welsh Council to the CMO raising concerns about changes to the Pfizer vaccination dosing interval and sharing a letter sent by the BMA Chair of Council to the CMO for England (M2B/PB/111 - INQ000118677, M2B/PB/112 - INQ000118678).

173. In response to the significant concerns raised by BMA Cymru Wales, the Minister and officials stated in meetings and publicly that they were not minded to change course and deliver second doses within the manufacturer's originally advised timeframe, reiterating their stance that the initial protections from the first dose had greater benefits in reducing deaths and easing pressure on the NHS.

VCOD (Vaccination as a Condition of Deployment)

The BMA supported a voluntary vaccination model

174. The BMA responded to proposed vaccine mandate proposals in England via official DHSC consultations, input into NHSE guidance and in media statements. Proposed changes included making vaccination a condition of deployment among staff in older adult care homes, followed by the expansion of the mandate to the health and wider social care sector. Ultimately, this policy was put in place in older adult care homes and later was revoked at the same time as being revoked for the wider health and social care sector (albeit prior to it being implemented more widely).
175. The BMA's priority was to support doctors and other healthcare workers getting vaccinated while listening to and addressing any concerns staff may have, emphasising that vaccinations are safe and effective in protecting against the disease. The BMA's view was that vaccination should be voluntary based on the principle of informed consent, being respectful of individual rights and liberties and that any move away from the existing voluntary model would need to be properly justified and proportionate. There are significant practical and ethical issues to consider in mandating vaccination. The BMA's view was that coercion was not the right approach for healthcare workers and could worsen the recruitment crisis and place unbearable pressures on the health system, if, for example, staff who refused the vaccine for personal or religious reasons, were no longer able to work. For example, a Government impact assessment on the care home sector found that 40,000 current members of the workforce may have chosen not to take up the vaccine before the end of the grace period (PB/647 - INQ000479113). The BMA's position was articulated in a BMA news article dated 10 December 2021 which was published on the BMA website (PB/651 - INQ000479117). The detail of the BMA's official position is outlined in our responses to various public consultations on vaccination mandates and is described below.
176. DHSC conducted a public consultation between 14 April and 26 May 2021 on an amendment to the Health and Social Care Act 2008. The amendment would require older adult care home providers to deploy only those workers who have received their COVID-19 vaccination in line with government guidance (unless medically exempt).

177. The BMA responded to the public consultation by way of letter to DHSC, dated 21 May 2021 (PB/735 - INQ000118342). The letter outlines the BMA's position on the proposed changes as follows:

- a. Given the particularly high vulnerability of those residing in care homes, it is imperative that residents are as fully protected as possible (the UK had already seen a tragically high number of deaths throughout the pandemic within this setting – with over 42,000 COVID-19 deaths in England and Wales alone in the period up to 21 May 2021 (PB/659 - INQ000479125)).
- b. Vaccination of both staff and residents plays a pivotal role in achieving the highest level of protection against the virus, alongside other IPC measures. More needs to be done to achieve the minimum level of uptake recommended by SAGE, which was 80% in staff and 90% in residents in each individual care home setting (PB/807 - INQ000501414).
- c. The proposal to make vaccination a condition of deployment raises a range of ethical issues. Vaccine hesitancy is a complex issue, spanning from dis/misinformation-fuelled doubts about efficacy, to general distrust in medical advice within groups who have historically been marginalised.
- d. There is a significant risk that mandating vaccination will entrench opposition, especially amongst those who have existing doubts. This is supported by a study which highlighted that pressure on this issue led to an erosion of trust. This lack of trust could contribute to the loss of staff.
- e. A voluntary approach to vaccination upholds autonomy to make private healthcare decisions. This also considers that there are some very small risks which individuals need to balance when deciding whether to be vaccinated. This argument can be weakened by the caveat that healthcare staff differ from the general population given they are subject to expected requirements as part of their duty of care to their patients. Although healthcare staff differ from the general population given they are subject to expected requirements as part of their duty of care to their patients, any restrictions on their autonomy needs to be proportionate

and it is necessary to consider the liberties of healthcare workers alongside ensuring the safe provision of services.

- f. There is an ethical imperative to prioritise the least intrusive method of achieving high vaccine coverage. The BMA outlined several methods for this, including engagement and education. The BMA also proposed that alongside engagement and education, the Government should explore the introduction of mitigating measures that could minimise the risk of transmission and may enable unvaccinated staff in care homes to continue working, such as the provision of enhanced PPE, additional infection control measures, and more regular testing for COVID-19 for patient-facing staff who are unvaccinated.
- g. The importance of high vaccination rates is highlighted, as well as the potential for risk of divisiveness. The BMA urged the government to proceed cautiously, prioritising engagement with staff and exploring mitigations against transmission.

178. On 16 June 2021, the BMA issued a press release (PB/639 - INQ000479105) in response to the government's confirmation that it would launch a consultation on the expansion of VCOD to healthcare staff in England. In it, the BMA UK council chair welcomed a proper consultation but warned that any specific proposal for the compulsory vaccination of healthcare staff against COVID-19 would raise new ethical and legal implications.

179. The consultation, which was about making both the annual flu jab and COVID vaccination mandatory for healthcare and other social care staff, ran from 9 September to 22 October 2021. In our response (PB/757 - INQ000481097), the BMA set out similar views to those expressed regarding mandatory vaccination in care homes:

- a. The BMA referenced its policy that every healthcare worker should be vaccinated against the flu and COVID-19 unless they have a medical exemption, but highlighted the distinction between believing that every healthcare worker should be vaccinated and advocating for mandates to achieve this goal. Uptake of the flu vaccination in the health workforce is generally lower than COVID-19 vaccination uptake but has risen

considerably over the past decade, leading the BMA to believe that a voluntary approach to vaccination is effective.

- b. The BMA highlighted ethical and practical considerations in respect to mandating vaccination, such as the restriction of liberty and privacy rights, and the possibility that it would entrench opposition.
- c. The BMA urged the government to explore other measures for preventing infection, such as regular testing and adequate provision of PPE, because vaccination is not a replacement for basic infection control measures. These measures in combination provide the most effective infection prevention control without the risks associated with mandating vaccination in a workforce already at critical staffing levels. A key concern was that even a small number of staff being excluded from the NHS could affect the ability of Trusts and practices to provide safe services. Pointing to the government's impact assessment on loss of workforce in care homes following mandatory vaccination, the BMA said that without a similar assessment for the NHS it would be difficult to make informed decisions about risks. Similarly, the consultation for the health and wider social care sector did not provide enough detail in its equality impact assessment, and said the government needed to take clear steps toward ensuring disproportionate impact on specific groups is mitigated.
- d. If the mandatory vaccination proposal was to become policy, the stance taken by the BMA was that every effort should be made to redeploy unvaccinated healthcare workers into non-patient facing roles. The response also suggests other measures such as remote consultations, but highlights the criticism faced by doctors on this issue.
- e. In relation to timeframes for implementation of such a policy, the BMA advised the government that a staggered approach should be taken, and that the ramifications on the workforce should be understood especially if it were to come into effect during the Winter.
- f. Finally, the BMA re-emphasised the significant redeployment opportunities available, and where there were not, advocated for an

enhanced redundancy package. Generally, the BMA expressed concern that the proposal represented a coercive approach, and that the UK government had provided insufficient clarity and justification of the need for the proposal. It also expressed that compelling vaccination should be a last resort in the instance that other methods had been trialled, evaluated, and shown to be ineffective.

180. In addition to responding to the public consultations, the Social Partnership Forum (which the BMA is a member of) also put forward its views to the Minister for Health via letter dated 15 October 2021 (PB/756 - INQ000481096). The letter describes the views of the SPF, namely that mandating vaccines would be counterproductive for Trusts and the government's policy aims and would place further pressure on an already understaffed healthcare system.
181. On 11 November 2021, the policy requiring anyone entering a Care Quality Commission (CQC) registered care home to be fully vaccinated came into force. However, the Health Secretary Sajid Javid announced on that same day that there would be a delay to the mandate for NHS healthcare workers in England to Spring 2022.
182. The BMA issued a press statement on 11 November 2021 (PB/648 - INQ000479114). In it, BMA UK council chair at the time, stated, "While the BMA has serious concerns about making vaccination mandatory, we're pleased that the Government has, as we recommended, decided to delay the policy of mandatory vaccination for Covid-19 until spring next year, and released both its workforce impact assessment and its equality impact assessment."
183. The delay to the mandate meant that healthcare staff in England must be fully vaccinated by 1 April 2022. This meant that non-compliance could lead to dismissal. Limited medical exemptions were allowed, such as severe allergies to available COVID-19 vaccines or serious adverse reactions to the first dose. The requirement was for healthcare workers to have received their first jab by 3 February 2022 in order to meet the 31 March 2022 cutoff.
184. The BMA published guidance ahead of the policy coming into effect providing information about the medical, legal, and ethical considerations (PB/653 -

INQ000479119). It contained information on how employment contracts could be affected as the result of redeployment undertaken for the purpose of the VCOD framework and information about doctors' rights. This guidance was updated following the government announcement that mandatory vaccinations for health and social care staff would be revoked.

185. The BMA also made comments on the phase 2 draft NHSE guidance issued ahead of the implementation of VCOD in the wider health and social care sector, which was presented to the SPF (PB/770 - INQ000481116). The BMA sought clarity on various parts of the draft guidance, particularly about the dates of notices of dismissal, reconfiguration and redeployment of staff, and equalities impacts. It appears that NHSE had addressed at least some of the BMA's comments.
186. The chair of the BMA's UK Council met with the SoS on 24 January 2022 to discuss VCOD. During this meeting, the BMA emphasised that it supports vaccination but also highlighted the need to ensure sufficient staffing levels as even small losses of staff can have a significant impact and questioned the cost-benefit ratio of implementing the policy and approximately 30,000 staff leaving the NHS. The BMA also said that COVID-19 vaccination policy should, going forwards, focus on preventing healthcare staff from severe disease. The BMA again called for improved IPC measures for NHS staff as this would reduce transmission of the virus (INQ000309514 – exhibited to the witness statement of the Sajid Javid dated 18 October 2023).
187. On 31 January 2022 the SoS announced that requiring vaccination as a condition of deployment was “no longer proportionate” and that, subject to a consultation and parliamentary approval, the regulations on mandatory vaccination for health and social care workers would be revoked (PB/656 - INQ000479122).
188. By this time, vaccination as a condition of deployment in care homes had been in place since 2021 and had reportedly led to 40,000 staff leaving their positions in the sector (PB/657 - INQ000479123).
189. This announcement was met with approval from the BMA. In a press release dated 31 January 2022 when the announcement was made, the BMA said that the Government's decision to scrap the policy requiring NHS workers in England to be vaccinated against COVID-19 as a condition of their employment is the right one,

warning that it could have had a 'devastating' impact on an already stretched workforce and therefore patient care (PB/655 - INQ000479121). The UK council chair stated that the decision to revoke the mandate was appropriate, offering a more proportionate approach that considers the evolving nature of the COVID-19 situation while safeguarding patient care and safety.

190. In an article published on 1 February 2022, the BMJ reported that medical bodies welcomed the reversal on the plan, which they had warned would exacerbate chronic workforce shortages in the health service by causing thousands of staff to lose their jobs (PB/657 - INQ000479123).

191. A third and final consultation survey regarding the revocation of mandatory vaccinations in care homes and the wider health and social care sector was run between 9 and 16 February 2022 (PB/778 – INQ000481126). The BMA's response expanded on its views which were set out in previous consultations noting that the strong preference was for these requirements be revoked (PB/776 - INQ000481124). The BMA reiterated its view that there are other steps that could be taken to increase vaccination uptake, and outlined again the stress that mandatory vaccination would place on the health workforce. The BMA again highlighted the ethical considerations and the potential exacerbation of existing inequality across groups with a protected characteristic, such as ethnic minority populations, those with a disability, or people who are pregnant. In relation to other actions the government could take if vaccination were not a condition of deployment, the BMA emphasised once more infection prevention measures, whilst stating that the government needed to increase its efforts to encourage everyone to get vaccinated, particularly vulnerable members of the public.

192. The proposed requirement for mandatory vaccinations among health and social care staff was ultimately retracted on 15 March 2022 (PB/660 INQ000479126).

J. Barriers to vaccine uptake

193. In the BMA's 2022 report 'The impact of the pandemic on population health and health inequalities', we commended the speedy development, authorisation, and deployment of COVID-19 vaccines as one of the biggest success stories of the

pandemic (PB/017 - INQ000185357). By the end of August 2022, ONS data showed that of those aged 12 years and over in the UK, 93.6% had received one dose of a covid-19 vaccine, 88.2% had received two doses, and 70.2% had received three or more doses. (PB/667 - INQ000401116).

194. However, while the overall uptake of the vaccine programme was high, we expressed concern that progress was not equal across the UK; this overall rate masked significant disparities in vaccine uptake, particularly along the lines of deprivation and ethnicity.

195. A number of studies sought to look at the reasons for vaccine hesitancy and lower uptake in certain groups. This included a report by the Nuffield Council on Bioethics on vaccine access and uptake (PB/631 - INQ000479097). These reports found that individuals' uptake of vaccination is influenced by a range of factors such as timing, availability, and location of appointments; accessibility of transport to and from facilities where vaccines are offered; childcare responsibilities, particularly for larger families; or indirect costs associated with vaccination, such as transport or taking time off work.

196. In the BMA's view there were several key barriers to uptake of the COVID-19 vaccine. Firstly, there were physical barriers to accessing vaccination sites, such as difficulties reaching the sites. For example, some mass vaccination centres were a considerable distance from people's homes or workplaces and could not be accessed via public transport routes. Accessing the vaccine was also challenging for those who were unable to leave home easily, such as elderly or disabled people. For those who were clinically vulnerable, many had a fear about leaving home and catching COVID-19.

197. Not having an NHS number became a barrier to vaccine uptake for many people in the homeless population, as well as for vulnerable migrants. Despite there being no need for a fixed address to access the vaccine, there were reports that some people still faced this barrier. This issue is examined in more detail later in this section.

198. There were also financial barriers to having the vaccine for some people, such as for those having to take time off work to attend the appointment, which may have affected their pay. This was not always easy for key workers or those working in the social care sector, or those with poor flexible working policies.

199. Communication barriers also existed for people who could not understand or access all the relevant information about having the vaccine, for example, in a linguistically or culturally appropriate way. Being unable to access the information in an easy-to-understand or accessible way may have also been a barrier for those with learning disabilities and deaf people who were, for example, excluded initially from government daily briefings due to there being no British Sign Language (BSL) interpreters. In the BMA's call for evidence to inform its COVID-19 Review, respondents emphasised the need for a vaccine programme that ensured that everybody could access the vaccine, regardless of their geographic location or support needs.

200. A significant cultural barrier to accessing the COVID-19 vaccine has been the lack of trust in health services and, by extension, the vaccine amongst some ethnic minority communities. Data on vaccine hesitancy, and more about the reasons for it amongst ethnic minority communities, are set out in more detail below. The BMA believes this could and should have been anticipated by the government and health service considering the deep rooted, systematic racism of the NHS and society in the UK (PB/672 - INQ000479138), as well as data from previous vaccination programmes. It is important to recognise that the term "ethnic minority communities" does not refer to a homogenous group, and between and within different ethnic groups there will be a range of viewpoints and experiences in relation to the COVID-19 vaccine.

Uptake of the COVID-19 vaccine was variable across different groups and particularly along ethnicity and deprivation lines.

201. Lower rates of COVID-19 vaccine uptake amongst some ethnic minority groups were seen across the UK, and throughout the different stages of the vaccination programme. Vaccine uptake in England, Scotland, and Wales was highest among those from a White ethnic background throughout. For example, in Wales, data from February 2021 show that uptake for the combined Black, Asian, Mixed and Other ethnic groups in people over 80 years old was 71.5 per cent compared to 85.6 per cent in the White ethnic group (PB/628 - INQ000479094). A more complex picture is revealed by the more granular data available in England and Scotland, indicating wide variation between ethnic groups. In Scotland, first dose uptake was lowest in African

groups for older age groups (55+ years), and first dose uptake was lowest in the Caribbean or Black group for younger age groups (<50 years) (PB/663 - INQ000147517). In England after adjusting for differences in age, the ethnic groups with the lowest proportion of people continuing to a fourth vaccination were Pakistani (34.8%), Bangladeshi (36.3%), and Black African (41.8%), compared with the White British group (78.1%) (PB/666 - INQ000414104).

202. There were also indications of vaccine hesitancy amongst some ethnic minority healthcare staff. The BMA supported the UK-REACH research into the impact of COVID-19 on ethnic minority healthcare workers (PB/643 - INQ000479109). The BMA promoted the research and attended some meetings of the stakeholder group (UK-REACH STAG). In July 2021, research published by UK-REACH (PB/641 - INQ000302493) found that healthcare workers from some ethnic minority groups (including Black African, Black Caribbean, and White Other) were more likely to be vaccine hesitant than their White British colleagues (contrastingly, our own research of BMA members did not find such differences, see paragraph 68). The research also found that healthcare workers were more likely to be vaccine hesitant if they were younger, female, pregnant, or had already had COVID-19.

203. Disparities in vaccine uptake were also seen along deprivation lines, as referenced in the BMA's 5th COVID-19 Review report (PB/017 - INQ000185357). As outlined in the report, data from 2022 showed that across England, Scotland and Wales, vaccine uptake was higher in areas of greater affluence and gradually decreased along deprivation lines. This gap in uptake was largest in Wales, with a 10-percentage point difference in uptake between the areas with the highest and lowest levels of deprivation. The picture in Northern Ireland was more complex, although the chief scientific adviser acknowledged deprivation was a factor in vaccine uptake.

204. ONS data published in March 2023 showed inequalities persisted in the COVID-19 vaccine booster programmes (PB/666 - INQ000414104). People living in the most deprived areas were least likely to continue to a fourth vaccination (63.8%), with vaccination rates increasing as levels of deprivation reduced.

There was evidence before COVID-19 that there was a risk of disparity in a vaccination programme.

205. Even prior to the COVID-19 vaccine rollout, there was evidence to suggest that lower vaccine uptake amongst people from ethnic minority communities was a risk. A systematic review published in 2022 found several studies published before December 2020 that would suggest an association between vaccine uptake and ethnicity (PB/661 - INQ000399401). Further, official Public Health England data on flu influenza vaccination showed lower uptake in the years preceding the start of the pandemic (PB/599 - INQ000479065), which, while not directly comparable to the COVID-19 vaccination programme, does indicate the need to pay particular attention to the potential for such disparities.
206. A paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE) that was considered in December 2020 shows that government advisers were aware that uptake of the COVID-19 vaccine may be lower in ethnic minority communities and stressed the necessity of community engagement (PB/610 - INQ000250215). The likelihood – or at least the potential risk - of disparity in vaccine uptake was therefore clear in the data before the vaccine rollout (based on intention to have the COVID-19 vaccine, and evidence of uptake of other vaccination programmes).
207. People from ethnic minorities and deprived communities also had worse health outcomes before the pandemic, and with this in mind, there should have been greater consideration of these groups in planning the vaccine rollout. For example, a man born in one of the most deprived areas of Scotland could expect to live 69.5 years, compared with 82.8 years for a man born in one of the least deprived areas, a gap of over 13 years (PB/605 - INQ000228404). *The Marmot Review: 10 Years On* report published in January 2020 found that based on PHE data, in 2019 half of the minority ethnic groups – mostly black, Asian and mixed ethnic groups – had significantly lower disability free life expectancy at birth than white British men or women (PB/601 - INQ000108755).

The reasons for the variability of the COVID-19 uptake are manifold, but the BMA would draw particular attention to the reasons for vaccine hesitancy amongst black and ethnic minority communities.

208. A survey by the Royal Society for Public Health in December 2020 found that only 57% of respondents from ethnic minority backgrounds (199 respondents) were likely to accept a COVID-19 vaccine, compared to 79% of White respondents. Confidence was lowest among respondents of Asian ethnicity, of whom 55% were likely to accept the vaccine (PB/609 - INQ000479075). This should have been an early indication of the need to proactively address the barriers to vaccine uptake in ethnic minority communities to ensure high take up of the vaccination.
209. In relation to ethnic minority communities, and Black communities in particular, the BMA argued in two of the BMA's reports on COVID-19 and health inequalities and elsewhere (such as a blog written about vaccine hesitancy on the BMA website – PB/625 - INQ000479091) that vaccine hesitancy in these communities groups has its roots in a mistrust of the medical establishment because of racial discrimination in the NHS, and historic abuse of international vaccine programmes. In our detailed response to the Commission on Race and Ethnic Disparities report, better known as the Sewell report, we argued that structural racism cannot be ignored when discussing racial health inequalities. In relation to mistrust of health services more generally, we also said that in addition to adequate translations of public health messages, building trust within different communities is an important way to reduce mistrust (PB/638 - INQ000118384). The importance of getting this right was highlighted in responses to the BMA's call for evidence as part of our COVID-19 review. At our Annual Representative Meeting in June 2022, our members passed a motion calling for the Association to acknowledge that mistrust and vaccine hesitancy among minority ethnic groups were not solely the result of misinformation about the vaccine (PB/662 - INQ000479128). The motion acknowledged that racial discrimination and a mistrust of the medical establishment played a significant role and backed moves to encourage Trusts and health boards to do more to engage and communicate effectively with patients from minority ethnic communities.
210. The BMA published a blog on 4 February 2021, which outlined vaccine hesitancy and mistrust in more detail (PB/625 - INQ000479091). The blog explored several

causes for this. As already mentioned, in black communities for example there is a deep-rooted mistrust of health services. People from ethnic minority groups have had historically different treatment and outcomes from their healthcare; black women for example are five times more likely to die in childbirth compared to white women. Women and ethnic minority people have often been underrepresented in clinical trials and there are relatively recent examples that clinical trials have taken place in countries in Africa without informed consent.

Misinformation about COVID-19 vaccinations and anti-vaccination messaging in the press and on social media likely also added to vaccine hesitancy.

211. The BMA believes that another key cause of vaccine hesitancy is around anti-vaccination messages and misinformation. In the BMA's COVID tracker survey in December 2020, 88% of nearly 6,000 respondents said they were concerned about how anti-vaccination messages would impact on uptake of the vaccine. The BMA called on the UK Government to take more action to tackle misinformation online and launched a social media campaign to address vaccine hesitancy, particularly amongst ethnic minority groups.
212. Beyond the hesitancy and mistrust in the vaccine amongst black and other ethnic minority communities in the UK, there were also pockets of society colloquially known as 'anti-vaxxers'. These include people who were and remain in total opposition to any vaccinations, as well as those with a specific opposition to the COVID-19 vaccinations.
213. BMA members in general practice reported to the BMA's *The Doctor* magazine incidences of abuse from anti-vaxxers in response to their practices sending out information about how to get the vaccine to their surgery's patients (PB/645 - INQ000479111). Some doctors spoke to the magazine about leaving social media after too many incidences of harassment and abuse on social media platforms. One GP surgery in Hampshire was stormed by anti-vaxx protestors, and staff threatened (PB/670 - INQ000479136).
214. In cases of vaccine hesitancy, mistrust and anti-vaccination sentiment, the common theme is a lack of trust in governments and/or health services. This may be

based on previous incidences of being let down or failed in some way by government or health services, either real or perceived as such.

The BMA made several recommendations to the UK Government to address the variation in uptake.

215. Throughout the pandemic, the BMA made several recommendations aimed at addressing barriers to vaccine uptake. In May 2021, the BMA responded to figures showing lower uptake among over-50s in all ethnic minority groups compared with the white British population, and among other less advantaged socio-economic groups, such as people living in deprived areas (PB/635 - INQ000479101). We asked the government to ensure information on COVID vaccines was distributed in multiple languages, with more 'innovative efforts' to engage with hard-to-reach communities, such as mobile vaccination units.

216. In our 2021 report 'Mitigating the impact of COVID-19 on health inequalities', we stressed the need for vaccine uptake to be as universal as possible, by making it as accessible as possible (PB/077 - INQ000118318). We advised Governments across the UK to put in place supportive arrangements to overcome the various barriers to vaccine uptake, which could include patient transport, specific access arrangements, and tailored messaging for certain groups alongside engagement through community leaders. We also said that any future vaccination programmes should consider the range of potential barriers to access and identify ways to ensure equitable access. We recommended that people from ethnic minority communities should be involved in decisions and mechanisms to improve equitable access to the vaccine. For groups who share protected characteristics, the BMA called in this report for urgent analysis to clearly set out any identified barriers to ensuring good vaccine access and uptake across all these groups. We said that the Government should make clear how these barriers would be overcome, and how progress would be monitored to ensure the vaccine programme was successfully reaching these groups.

217. The BMA also took action in response to concerns that vulnerable migrants, and homeless people may be deterred from seeking healthcare during the pandemic, including access to vaccines when they became available. In April 2020, the BMA,

along with a broad coalition of health and care organisations, signed a letter from Doctors of the World to the Secretary of State for Health and the Home Secretary calling on them to suspend the National Health Service (Charges to Overseas Visitors) Regulations 2015 and 2017 and all associated immigration checks and data sharing which risked undermining the Government's pandemic response and deterring people coming forward for healthcare for fear of immigration enforcement (PB/279 - INQ000235275). The BMA also published guidance on our website to clarify GP registration guidance, and to be clear that proof of address was not required to register a patient with a practice and that homeless people should be able to register using a temporary address (PB/654 - INQ000479120). In 2022, the BMA's General Practitioner's Committee in England endorsed the Safe Surgeries Toolkit produced by Doctors of the World which supports GP practices to promote inclusive care through GP registration and aims to address the specific barriers to primary care faced by un/under documented migrants in vulnerable circumstances (PB/620 - INQ000479086).

218. Regarding communication about the vaccination programme, the BMA highlighted the issue of online dis- and mis- information as a barrier to uptake (PB/624 - INQ000479090). Shortly after this, we launched our social media campaign tackling dis- and mis- information, discussed in more detail later in this statement. The need for governments to do more to combat misinformation was also raised by respondents to the BMA's call for evidence as part of our COVID-19 review. For example: a Public Health Consultant in England said: *'[There is] the need for clear and consistent public messaging and for the involvement of community leaders in informing and supporting populations to come forward for vaccination.'* A resident doctor in Northern Ireland said: *'Communication is key, and as with so much else, the government's communication was woeful. Even now, the community are confused as to why the vaccine is not eradicating covid. End result being that people are not careful enough and we have ongoing problems in society and healthcare.'* Finally, a salaried GP in Wales stated that: *'I would have liked to see clearer public health messaging about the benefits of vaccination to try to counter the disinformation on social media (and stronger sanctions for those spreading disinformation).'*

219. Respondents in the same call for evidence also emphasised the need for vaccine programmes to be culturally sensitive and accessible. Respondents included a SAS doctor in Scotland who said: *'More direct engagement with the population [is needed], particularly the most affected groups and those most reluctant regarding vaccination. Education to be carried into the social meeting areas and working with community leaders (for example religious groups, Youth Clubs, cultural establishments etc.)'* while a GP in England said: *'An apolitical communication team [is needed], skilled in cascading messages in many languages and collaboration with BAME community groups.'*

220. In February 2021 the BMA asked that the Government should make information available in as equally accessible format as possible to ensure everyone had all the information available to make informed choices (PB/625 - INQ000479091). We said it was the responsibility of the authorities to make the information clear and accessible for whoever the intended recipient is and for whatever reason - and that a 'one size fits all' was not an acceptable communication strategy for the entire population of the UK. We also expressed that communications about the vaccine must be made accessible and understandable for people with learning disabilities.

GPs were also involved in efforts to increase vaccine uptake amongst their patients.

221. In April 2021 the BMA's magazine for members, *The Doctor*, published an article about the role that GPs were playing in helping to ensure their most vulnerable patients accessed their vaccine (PB/632 - INQ000479098). The article described how some GPs, with the support of their Clinical Commissioning Groups (CCGs), contacted individual patients from many of the at-risk groups personally about the vaccination to encourage uptake.

222. When asked by *The Doctor* how they conducted these conversations, the interviewed GP said *"You can't be too dogmatic, this isn't about lecturing them. You are there to listen to their concerns but then to explain why what they have been thinking isn't quite right, why they might not have the right information, or to explain why it is actually really important."*

223. In the same piece, the GPCE Chair at the time, added *“This is a good example of how local practices have a good relationship with their patients and understand their local community, making a big difference to vaccine uptake. It’s why the vaccination rates have been so high across the country and the programme has been so successful. Where there is a need to reach out to particular individuals and groups and give them more time to discuss their questions or anxiety related to the vaccine this would be helped by additional support to cover the time involved.”*

224. GPCE also played a role in addressing certain issues that were being highlighted by GPs and vaccination centres about vaccine efficiency and ensuring people were able to access their vaccine. For example, in May 2021 GPCE raised an issue that had been highlighted to them about parents being denied access to their vaccination appointment due to having dependent children with them (PB/637 - INQ000479103). As a result, NHSE issued guidance making it clear that parents with dependent children should not be turned away and highlighting that reasonable adjustments should be made for people in such circumstances and that every effort should be made to ensure that individuals can receive their vaccine at their appointed time (PB/731 - INQ000481046).

The BMA partnered with creative agencies to run a social medial campaign to increase vaccine uptake and help address hesitancy.

225. At the beginning of 2021, the BMA sought to address the higher levels of vaccine hesitancy and mistrust in black and ethnic minority communities in the UK.

226. As a result of the (previously mentioned) blog about the reasons for vaccine hesitancy and mistrust, the BMA was approached by the creative agencies Motel and Incense in February 2021, who wanted to partner with the BMA for a campaign, offering their services for free. They had identified and spoken to trusted social media influencers from ethnic minority backgrounds who could communicate the benefits of the vaccine to their followers, many of whom were also from ethnic minority backgrounds. The rationale was that high levels of distrust could be best tackled by someone of a similar ethnic background recognising the valid concerns and fears of their communities and reassuring their followers of the safety of the vaccine. It was

also intended to counter some disinformation and misinformation about the vaccine circulating on social media. A study by King's College London published in June 2020 found that people who used social media as a significant source of information about COVID-19 were more likely to believe conspiracy theories linked to the virus (PB/602 - INQ000479068). It also found a 'statistically significant' link between believing in conspiracy theories and breaking lockdown rules such as going out in public with COVID-19 symptoms.

227. It was hoped that those people who watched the campaign videos could go to friends and family members armed with the facts and figures they needed to allay their concerns and convince them to get the vaccine. After meeting with the two creative agencies, the BMA agreed to work with them on a social media campaign to encourage vaccine uptake. It was decided that the BMA would act as a scientific and medical policy advisor to the campaign, and provide the facts and figures needed to support people to be informed enough to make the best choice possible for them and their families. The campaign was entitled 'Spread the Word, Not the Virus' and ran from May 2021 over that summer (PB/636 - INQ000479102).

228. The campaign saw several social media influencers (on platforms such as TikTok and Instagram) create short videos in which they talk about some of the common misconceptions about the vaccine and share facts supporting the message that the COVID-19 vaccine is safe. Some clips from some of the videos were combined into one video which was published on the BMA Instagram account, which explained that getting the vaccine would mean people could safely spend time with friends and family, among other positive effects. The influencers' posts signposted to a link to the BMA website which held accurate and up to date information about what people needed to know about the vaccine. This took the form of a Q&A designed by the BMA's policy and campaigns department (PB/619 - INQ000479085).

The BMA also sought to address vaccine hesitancy and misinformation in other ways.

229. Elsewhere on social media, the BMA encouraged doctors to use the #Hadmyjab hashtag, asking doctors to share a picture of themselves getting the vaccine. This began in December 2020, and the BMA periodically reposted social media posts of

doctors receiving their COVID-19 vaccine for around 12 months (see for example PB/615 - INQ000479081). We hoped that for people from certain ethnic minority communities, pictures of doctors from the same ethnic background receiving the vaccine would be particularly helpful and reassuring owing to their suspicion of health services.

230. The BMA and others also called on the Government to devise and implement binding standards that compel social media companies to actively prevent dispersal of false or misleading vaccine information online (PB/600 - INQ000479066).

231. Additionally, from the first year of the pandemic the BMA had called on the Government to provide culturally tailored public health communications (PB/005 - INQ000098756), as previously discussed. Amongst other activities, the BMA encouraged the government to follow the recommendations of the Independent Scientific Pandemic Insights Group on Behaviours (SPI-B), when designing public health messaging (PB/604 - INQ000213990).

Efforts were made by governments and by local health and care service leaders to address vaccine hesitancy with some success but inequalities remained and efforts were not always sustained.

232. The BMA acknowledges that in 2021-22 various efforts were made by health services, local governments, and community leaders to try and address barriers to vaccine uptake, with much of it focusing on addressing the historic mistrust of the health services amongst ethnic minority groups. This included using places of worship as vaccination centres, developing targeted videos with faith and business leaders, and holding webinars in partnership with community associations. While some groups remained distrusting, these efforts likely meant that levels of vaccination among these groups were higher than they otherwise would have been. For example, the UK government launched the Community Champion Scheme in January 2021. This programme likely contributed to the positive increase of vaccine uptake across all ethnic groups. Between 31 May and 31 October 2021, the percentage of over 50s who received both doses increased in all ethnic groups. Notable increases were observed

in the Pakistani group (from 54.2% to 78.8%) and the Bangladeshi group (63.7% to 87%) (PB/649 - INQ000479115).

233. In our 2022 report on 'The impact of the pandemic on population health and health inequalities' (PB/017 - INQ000185357) we acknowledged that while efforts to reduce vaccine misinformation had been somewhat effective, marginalised groups were continuing to have negative experiences of healthcare services, and that regaining the trust of ethnic minority groups needed to be a priority for the NHS. We said that another area for improvement concerned the timely translation of public health communications into languages other than English or Welsh. Accessible and up-to-date information on how to protect themselves from a fast-spreading disease such as COVID-19 likely would have allowed ethnic minority groups whose first language was not English or Welsh to better protect themselves.

234. In June 2020, in response to evidence and concerns about the unequal impact of COVID-19 on different groups, notably those from ethnic minorities, and publication of the review of ethnic disparities by Public Health England, which the BMA had been the first organisation to call for, the Equalities Minister was tasked with undertaking further work to understand the key drivers of this unequal impact and the relationship between the different risk factors. This work was undertaken by the UK Government's Race Disparities Unit and was commissioned to produce four quarterly reports (PB/606 - INQ000089742, PB/629 - INQ000089744, PB/646 - INQ000479112, PB/650 - INQ000089747). Several of these reports included a focus on disparities within the COVID-19 vaccination programme. These reports set out the wide range of activities and initiatives the Government undertook to increase vaccine uptake in those groups who had lower vaccine uptake, which were welcome. It also made recommendations for the future. The final report stated that it was important to continue to build trust in communities where this was low. It also stated that it was important to learn from the practical lessons of the COVID-19 vaccine programme and to apply these to current and future vaccine programmes including COVID-19 boosters and winter flu programmes. The report also highlighted the need to take steps to improve the quality of health ethnicity data to allow earlier identification of trends and issues relating to vaccine uptake. The BMA is concerned that these important recommendations have not necessarily been taken forward and efforts to build trust and overcome vaccine

hesitancy have not necessarily been sustained. Data on ethnicity in terms of vaccine uptake, for example, are no longer published. In addition, there are worrying signs that other disparities persist. From data of the Spring 2023 COVID-19 booster programmes in England, for example, it is concerning that there is much lower uptake of the vaccine by immunosuppressed people (41%) compared to all people over 75 (71%) (PB/668 - INQ000479134), which may be due to factors such as access to vaccination centres or concerns about lack of protections in place in vaccination centres to protect vulnerable people from the risk of infection.

K. Inequalities

The BMA believes more could have been done to identify the needs of vulnerable groups ahead of the vaccination programme, particularly in light of pre-existing health inequalities that were well known

235. The BMA's advice was not specifically sought to identify different groups of people including those at risk, and other vulnerable groups and/or those with protected characteristics under the Equality Act 2010, in respect of matters within M4, although the BMA had some involvement, primarily in England and Wales in relation to helping identify people who should be asked to shield. Many of these people will have been in the initial priority groups to receive the COVID-19 vaccinations. As outlined in the previous section, the BMA believes that the needs of some vulnerable people were not sufficiently identified in advance of the vaccination programme. Once the vaccination programme was underway, they were identified when it became evident that the vaccines were not reaching all groups of people equally across the UK population, making some people more vulnerable to catching and the effects of COVID-19. Issues in relation to disparities among ethnic minority groups has been extensively covered in Section J. Other vulnerable groups in the pandemic included older people and people classified as clinically extremely vulnerable. These groups were given priority access to the vaccine, so their needs were better identified and better met by ensuring they were able to access the vaccine early. People with a learning disability however were not initially included in the priority list of people to access the vaccine (PB/614 - INQ000479080).

236. The government's decision in February 2021 to include people with learning disabilities in the COVID-19 vaccination priority list was a welcome one, but one which only happened after a legal challenge. By the time the vaccine was available in December 2020, we knew from a Public Health England report that people with learning disabilities had a death rate from COVID-19 up to six times higher than the general population (PB/608 - INQ000279971). Prioritisation in the vaccine programme was a key policy to mitigate the effects of existing inequalities, and so it is regrettable it took so long to implement this policy for people with learning disabilities.

237. Pregnant women were another group which had needs that were not sufficiently met in relation to the COVID-19 vaccines. Changing government advice led to confusion amongst those who were pregnant, or who were considering pregnancy, about whether they should be taking the vaccine. A poll of 56,000 people in December 2020 found that a quarter of women aged 18-34 said they would not take the COVID-19 vaccines due to concerns about the vaccine's effect on fertility and pregnancy (PB/622 - INQ000479088). The confusion should have been avoided, as pregnant women were at higher risk of severe disease from COVID-19. It wasn't until April 2021 that the Government clarified the advice for pregnant women, offering the vaccine to everyone and clarifying its safety in pregnancy and effects on fertility (PB/633 - INQ000376222). This changing advice left many pregnant women vaccine-hesitant and unprotected from COVID-19. In the BMA's call for evidence some respondents who were pregnant at the start of the vaccination campaign described this changing advice as "unhelpful" and "vague". Some also described barriers to accessing the vaccine even after the advice had changed, for example a Consultant in Wales said *"despite a written policy document, and a letter of 'permission' from my obstetrician and midwife, I was initially refused vaccination when I arrived at my allocated appointment"*. Later in the pandemic, in November 2021, the BMA spoke publicly about pregnant women having been let down by the lack of clear guidance about the vaccine's safety issued by NHS England and the UK Government (PB/808 - INQ000505535).

L. Lessons learned

The vaccination programme was a success but there was room for improvement

238. The BMA generally viewed the vaccination programme as one of the biggest successes during the pandemic and recognised the immense efforts of doctors, the wider healthcare workforce, and volunteers who drove the rollout's effectiveness and efficiency. Without their commitment to administering doses, the UK would not have been the nation globally to have administered more first doses per 100 people than any other nation of comparable population size by February 2021 (PB/626 - INQ000479092).

- a. This came against the backdrop of severe chronic workforce shortages across health services, particularly in General Practice. For example, by December 2020 (when the vaccine was first offered) England had the full-time equivalent of 28,036 fully qualified GPs – down from 29,364 in September 2015. By July 2021, the situation had worsened further, with just 27,750 fully qualified GPs (PB/673 - INQ000479139).
- b. In July 2024, the average number of patients per GP had increased by 18.3% since September 2015 to 2,293 (PB/805 - INQ000505536). How future vaccination programmes will be staffed must be considered as part of pandemic planning exercises. It makes it even more important for health services to be adequately staffed and the decline in GP numbers to be addressed so there is some capacity in the system to deliver any required future large scale vaccination rollout.

239. The success of the vaccine rollout was not without caveats for improvement. For example, calls for improvements to the vaccine supply chain were made at various stages of the vaccine programme. In a letter to DHSC in January 2021 (PB/706 - INQ000400483), the BMA highlighted that the approach to delivery and availability of vaccines had created uncertainty amongst medical practitioners regarding what they could provide to their communities, and when. This was driven by variation in deliveries, despite doctors showing that they could very quickly administer vaccines if they were delivered, even in large quantities. Some places were able to get their clinics running very quickly, but it took longer in others. As vaccine supply had to be directed

to areas that had been slower starting, some places were left having to wait (even though they had capacity and willingness to deliver) whilst provision was balanced. In some areas vaccination sessions had to be cancelled at the last minute because vaccine was not available and had been directed elsewhere in the country. The repeated short notice of vaccine supply has continued to be a problem with COVID-19 vaccination even in 2024 but it was a major problem in the early days with staff having to book large clinics with very little notice. There was also concern that services using the national booking service received more guaranteed supplies than GP practice run sites. In the same letter it was stated that more needed to be done to improve the invitation process, many patients having received letters separate to those received from their local community practice.

240. The BMA observed similar issues in Wales, saying in a press release in December 2020 (PB/617 - INQ000479083) that healthcare providers were struggling to access vaccinations in some parts of Wales and criticising the lack of transparency around delivery schedules, as well as the disparity in the rollout for staff in different health boards. There were reports of some areas being able to move forward with vaccination of staff, while others struggled to book a vaccine through email or phone lines. BMA Cymru Wales also called in December 2020 (PB/613 - INQ000118662) for the most vulnerable groups of frontline healthcare staff (such as older and BAME staff) to be vaccinated first by health boards. This followed prior requests for a national approach to staff vaccination, however as prioritisation decisions had been delegated to Health Boards, the BMA observed varying approaches across Wales.

241. The BMA canvassed its views and the views of its members regarding the vaccine rollout within its COVID Review reports. In report one, it was stated that 90% of medical professionals who responded to our call for evidence expressed a favourable view of the vaccine programme (PB/013 - INQ000118474). However, there were differing experiences across the medical profession during the rollout, particularly for staff receiving their first dose. Some groups more commonly reported difficulties in accessing their first vaccination, particularly resident doctors, GP locums, medical students who were not yet deployed and doctors working in private practice. Other contributing issues included changes to advice, for example for pregnant individuals, as well as difficulties booking in their vaccination. The BMA lobbied for frontline health

and social care workers to be prioritised for receiving the vaccine first and were successful – a list of nine priority groups was published by JVICI with frontline health and social care workers in the second priority group.

242. The action of a large-scale booster programme in December 2021 to curb the Omicron variant was viewed by the BMA as highly successful, however it placed a strain on healthcare services, particularly general practice. The booster offered a third jab to everyone over the age of 18, three months after their last vaccine, and a fourth jab for those who had already received three, such as those who were immunocompromised. This was led by the NHS, with doses increasing from 19 million to 34 million within the space of a month. The BMA had highlighted the importance of expanding vaccination through a booster programme, but months prior to its implementation in December 2021. Despite its success, the BMA's view was that all four UK governments should have altered their strategies sooner.
243. In its third COVID report (PB/015 - INQ000185355), the BMA pointed to the expectation of healthcare staff to return to normal patient-facing appointments and other primary care that had built up as backlog, and to also continue to administer vaccines at the same rate. This placed an immense amount of pressure on doctors already operating at maximum capacity, and the BMA wrote to the government to set this out in a letter in September 2021 (PB/234 - INQ000097914).
244. Whilst the BMA recognises the success of the vaccination programme, the significant disparities in uptake cannot be ignored. For those most at risk of, and from, infection and severe symptoms, the rates of vaccination were lower. The rate of vaccination gradually decreased along deprivation lines across the UK, and there were disparities among ethnic minority groups across England, Scotland, and Wales (ethnicity data were not available for Northern Ireland.) The barriers to vaccination identified in this report, such as vaccine mistrust, must be addressed if the UK is to be prepared for any future pandemic. Moreover, the disparities in access to the vaccine lay bare the disparities in access to healthcare more broadly, and therefore highlight an important area for governments across the UK to prioritise for urgent improvement.
245. There could have been further improvements to the vaccine rollout had there been earlier engagement regarding planning. The excessive security clearance needed for the BMA to be involved in early discussion about different vaccinations and how they

would be given was a problem that prevented the BMA from being engaged earlier and which could have allowed discussion about the enhanced service earlier (with less time pressure to agree before deployment in December 2020) and which would have therefore given practices longer to plan, rather than just a few days. Difficulties with logistics, communications and IT systems could have been lessened, and pressure on the medical profession could have been reduced. Approaches taken to provide information to those communities with existing disparate health outcomes could have been strengthened.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signature:

Personal Data

Name: Philip Banfield

Date: 15.11.2024