

Witness Statement: Humza Yousaf

Statement No: 4

Exhibits: HY4

Dated: 23 October 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF HUMZA YOUSAF

In relation to the issues raised by the Rule 9 request dated 1 July 2024 in connection with Module 4, I, HUMZA YOUSAF, will say as follows: -

Personal Details

1. My name is Humza Yousaf of the Scottish Parliament, Edinburgh, EH99 1SP.
2. During the date range of the request, 1 March 2020 until 28 June 2022, I was initially the Cabinet Secretary for Justice and then the Cabinet Secretary for Health and Social Care. I was appointed Cabinet Secretary for Health and Social Care on 19 May 2021 and held this post until 28 March 2023. Thereafter, I was the First Minister of Scotland from 28 March 2023 until 7 May 2024. My current role is serving as the Member of the Scottish Parliament for the Glasgow Pollok constituency.
3. As Cabinet Secretary for Health and Social Care I was responsible for the strategy, policies and legislation that underpins the delivery of health and social care in Scotland.
4. This witness statement relates to the matters addressed by the Inquiry's Module 4, which is considering vaccines and therapeutics.
5. I have previously assisted the Inquiry. In respect of Module 2A, I provided written statements dated 2 November 2023 [INQ000273956], 16 November 2023 [INQ000273973] and for Module 3, I previously provided a written statement dated 16 August 2024 [INQ000480774]. I also appeared at the Inquiry on 25 January 2024 to provide oral evidence in respect of Module 2A. Therefore, while this written statement is

self-standing, the reader may also wish to refer to my earlier statements and evidence for further information.

6. In the preparation of this statement, I have referred to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiries Response Directorate, solicitors taking my statement via interview and other appropriate assistance to enable the statement to be completed. I have also been assisted in identifying documents and factual information relevant to the questions being asked to assist in the preparation of my statement. However, any views or opinions expressed in this statement are my own.
7. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.
8. References to exhibits in this statement are in the form HY4/000 - INQ000000.

Structure, Role, People and Processes

9. In my role as Cabinet Secretary for Health and Social Care, health boards across Scotland were ultimately accountable to me. I held primary responsibility for the Health and Social Care Directorates within the Scottish Government and NHS Scotland. My responsibilities covered the areas of both health and social care and involved doing everything possible to improve the health of the country. However, a lot of day-to-day operational responsibility, was in practice devolved to Scottish local authorities and to the territorial health boards. I worked closely with health boards and local authorities to improve public health in Scotland, and of course to respond as effectively as possible to the Covid-19 pandemic, as well as recover our healthcare systems in Scotland from the effects of the global pandemic.
10. My specific responsibilities included:
 - acute services;
 - allied healthcare services;
 - centre of excellence for rural and remote medicine and social care;
 - community care;

- eHealth;
- health and social care integration;
- health improvement and protection;
- NHS estate;
- NHS performance;
- patient services and patient safety;
- person-centred care;
- primary care and GPs;
- quality and improvement;
- unscheduled care; and
- workforce, training, planning, and pay.

11. During May 2021- June 2022 I primarily worked with the following with regards to vaccines and therapeutics:

- The Scottish Government Vaccines Division (full details are provided for this in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01), particularly the Deputy Director Derek Grieve.
- I worked with Caroline Lamb DG Health and Social Care and CEO of the NHS, and John Burns NHS Chief Operating Officer. I also spoke weekly with the Chairs and CEOs of the individual Health boards.
- In regard to clinical advice, I worked largely with Senior Clinicians involved in the FVCV programme, such as Professor Sir Gregor Smith – Chief Medical Officer (CMO); Professor Alison Strath – Chief Pharmaceutical Officer (CPO); Professor Nicola Steedman – Deputy Chief Medical Officer (DCMO); Dr Syed Ahmed – Senior Medical Officer (SMO); Dr Lorna Willocks – SMO (took over from Dr Syed Ahmed); and Professor Jason Leitch, National Clinical Director (NCD).

12. I also worked with the then First Minister (FM), Nicola Sturgeon MSP, and the Junior Ministers in the Health and Social Care portfolio, who were Maree Todd MSP for Public Health, Women’s Health and Sport and to a lesser extent Kevin Stewart MSP, Minister for Mental Well-being and Social Care. The Special Advisors (SpAds) David Hutchison, Elizabeth Lloyd, and Callum McCaig would also have supported us in this respect.

13. Outwith the Scottish Government I would have liaised with the UK Government (UKG) Vaccines Taskforce, the UKG Vaccine Deployment Minister – Nadhim Zahawi, the UK Health Secretaries Matt Hancock and Sajid Javid, the Welsh Health Secretary Eluned Morgan, and the Northern Ireland Health Secretary Robin Swan. I would also meet with representatives from various stakeholders, BMA, Royal College of GPs, Scottish Care, and the RCN. Alison Strath (CPO) and I would also on occasion meet with the drug companies e.g. AstraZenca and Pfizer to discuss such things as adequate supply of vaccines and the development of the next phase of vaccine and research.
14. In the Scottish Government the FM had overall responsibility for our response to the Covid-19 pandemic, but as Health Secretary I was lead on and had ultimately responsible for the vaccination programme, amongst other responsibilities. Having said that, the FM did take a significant interest in the programme and regular updates were passed to her Private Office during the course of the programme. Indeed, she received direct daily updates not just from officials but directly from me around critical points of the programme e.g. “boosted by the bells” – which was the early period of the Omicron variant. She also asked many questions and for particular updates, for example, about vaccination rates or reports of delays or even closures of particular vaccination centres. She would also be updated at Cabinet if necessary. The Deputy First Minister (DFM) at the time, John Swinney was not particularly involved in the vaccine programme, however we had regular engagement particularly due to the cross-government nature of his responsibilities and due to his specific remit over resilience.
15. The transfer of responsibility between myself and Jeanne Freeman was relatively seamless. The Vaccines division had been established in June 2020 which meant that by the time I took over in May 2021, the team was a well-oiled machine for administering vaccines. In my view, relationships with UKG and health boards on the issue of vaccines were well established and while there was always going to be tensions and issues arising, on the whole the relationships were positive. Jeane made it clear that she would always make herself available when and if required and there were occasions where I did message her for advice, guidance, or to query certain matters.
16. There was a four nations approach to procurement of the vaccines which generally worked well. Funding of the vaccination supply and distribution was managed by UKG Government, and NHS Boards in Scotland received population share of doses. Through 2020-21, once vaccinations were on-stream, NHS Boards were asked to complete regular returns on their anticipated and, eventually actual, costs of administering doses.

Barnett Consequential funding was then used to cover Board costs incurred in delivering the vaccine. Local authorities were required to complete cost submissions for the use of premises as vaccination centres. During the time I was Cabinet Secretary for Health and Social Care, there was no significant funding issues on the issue of vaccines that I can recall, other than when the UK Government unilaterally cancelled their contract with Valneva.

17. In March 2022, Scottish Enterprise awarded a grant to French pharmaceutical company Valneva Scotland Ltd, in order to develop a manufacturing facility in Scotland which would play an important role in Scotland's life sciences sector, and in the global manufacture of vaccines. The Scottish facility is an important asset, developing and manufacturing vaccines for prevention and treatment of many infectious diseases and supporting high-quality jobs. A demonstration of that importance was the scale of the initial Scottish Enterprise funding, which included £12.5m to support Covid-19 vaccine work, however the funding was revised when the company suspended development of the vaccine after the EU significantly reduced its order from 60 million to 2.5 million doses in July 2022. Although the Valneva Covid-19 vaccine was approved for use by the MHRA, it has not been deployed in the UK after its Covid-19 contract was unilaterally cancelled by the UK Government in September 2021, prior to any use in the national programme. I was notified of this decision by a telephone call from Sajid Javid on 22 Sept 2021. I fully appreciate that it was the UKG's right to do this, it was ultimately their contract, but it was bitterly disappointing as this could have provided the UK with a source of home grown vaccines for future pandemics and provided a number of high quality jobs. What further frustrated me was, that a decision that could impact investment and jobs in Scotland, was taken without any prior consultation with me or with any member of the Scottish Government. There was no indication this decision was coming down the tracks. I would have expected some level of prior engagement when UK Ministers were considering the possibility of cancelling the contract, but it was clear the Scottish Government's opinion, in this case, was not a factor in UK Government decision making. I believe the UK Government should have considered a range of factors, from the importance of a domestic vaccine manufacturing base located in Scotland, to the jobs potential if the contract had been maintained. If a range of factors were considered, and there had been prior engagement with the Scottish Government, I believe that a different conclusion would have been reached regarding the Valneva vaccine. Unfortunately, this decision is a demonstration of the mistrust that existed in UK Government circles towards the Scottish Government.

18. During the pandemic other Ministers and I would regularly receive clinical /scientific advice in relation to vaccination. That advice came from a number of individuals, already referenced in this statement. There was also a number of UK bodies who helped inform our considerations in regard to the vaccine, the one we engaged with most significantly and frequently was the JCVI (Joint Council on Vaccinations and Immunisation). Any ethical considerations would be informed by appropriate clinical advice on the particular matter, and ultimately decisions were made by Ministers. An example of such a consideration was around the impact of vaccination on young children. Some initial data showed that one of the, albeit rare, side effects of the vaccine was an increased risk of heart conditions myocarditis and pericarditis in young children. Therefore, there was an ethical consideration to make, weighing up the benefit of vaccination versus the potential risk of the virus to specific cohorts, and indeed to the wider population. Other ethical considerations included the order of prioritisation of the vaccine – this was always informed by JCVI advice. There were also calls for some groups of workers to be given priority vaccination (health workers, police etc.). This consideration had to be weighed up versus consideration on supply of vaccine (e.g. how much prioritisation could be given to ANY group at all). Overall clinical and scientific advice was hugely important in these balancing exercises.
19. Although JCVI and clinical /scientific advice we received was immensely important I did feel able to challenge it. Indeed, the FM (Ms Sturgeon) and myself questioned JCVI initial recommendation not to vaccinate children. On 3 September 2021: JCVI advised against the universal offer of vaccination for those aged 12 to 17. Their recommendation was to expand the list of underlying health conditions that make those aged 12 to 15 eligible for a 2-dose vaccination schedule. I challenged this issue with Scottish Government health officials and our CMO. The CMO provided me with further advice aligning his view with JCVI advice. However, days later the JCVI asked the four nation CMOs to provide advice on the vaccination of 12- to 15-year-olds, taking into account a broader perspective, such as the impact on children to their education if they caught the virus, provided [HY4/001 – [INQ000408141](#)]. On 13 September 2021 the CMOs then came back with a recommendation of a universal programme of vaccination to otherwise healthy 12 to 15-year-old children, taking account of broader societal issues in contrast to what the JCVI had initially recommended. This was informed by a range of expert input, considering both the JCVI findings on marginal but positive health benefits alongside the likely benefits of reducing educational disruption and the consequent reduction in lifelong public health harm from educational disruption.

Key Decisions, actions and documents

20. A chronology of key dates in relation to my involvement with the matters before the Inquiry in this Module are exhibited. Of particular note were Autumn / Winter vaccination programme 2021; vaccination of students; vaccination of children; covid certification scheme. [HY4/002 – INQ000376297, HY4/003 - INQ000501318, HY4/004 - INQ000501311, and HY4/005 - INQ000502204.]
21. I have also exhibited key minutes / policy and guidance documents which were relevant to my involvement in Vaccine and therapeutics during the period and are provided, [HY4/006 – INQ000078605, HY4/007 - INQ000078612, HY4/008 - INQ000214470, HY4/009 - INQ000078631, HY4/010 - INQ000078606, HY4/011 - INQ000078622, HY4/012 - INQ000078613, HY4/013 - INQ000147412, HY4/014 - INQ000147413, HY4/015 - INQ000147414 and HY4/016 - INQ000235137.]

Development, procurement, manufacture and approval of the Covid-19 vaccines

22. As the Scottish Government was not responsible for the development, procurement, manufacture or approval of Covid-19 vaccines, I did not really have a significant role or any responsibilities as such in this regard. The vaccines had already been developed and approved when I took up office in May 2021. I had discussions with AstraZeneca and Pfizer but that was about supply and development of future phases of the vaccine, not manufacturing per se. We did not hold any contracts with vaccine manufacturers for the development or procurement of the Covid-19 vaccine. These were all dealt with on a four-nation basis by the UK Government with appropriate governance put in place via the Vaccine Taskforce. Four nations procurement of vaccines was common prior to the pandemic for large scale vaccination programmes as it historically offered economies of scale and supported the four nations utilisation of any limited stock to protect those most at clinical risk.
23. The Vaccines Taskforce (VTF) was a UK body with no Scottish Ministerial representation. Scotland was represented in this forum by the Immunisation Coordinator for NHS Lothian, Dr Lorna Willocks, who was co-opted as a member of the Committee for input on operational issues affecting Health Boards in Scotland. Dr Willocks would often attend regular meetings with me and vaccine officials and provide updates. I would discuss various issues on vaccines with my ministerial colleagues in the other four nations governments. This would be at Ministerial level, VTF colleagues would rarely if

ever join us. In such discussions I would for example seek assurances from the UKG that supplies would be sufficient for Scotland's needs, particularly for the autumn/winter and spring booster campaigns we had planned, at times there would also be discussions about the latest iteration of JCVI advice that had been issued or was imminently pending.

24. As I have said the decision making for the development, approval, manufacture and procurement of the Covid-19 vaccines was a responsibility of the UKG and they generally kept us well apprised of the situation. Indeed, I think the relationship between UKG and the Scottish Government was at its best on the issue of vaccines. The conversations between officials, and between Ministers were highly effective and generally worked well. There was a good channel of access between Ministers in each government. The only real issue I had with the UKG that was vaccine related was in respect of their handling of one vaccine manufacturing facility, Valneva Scotland Ltd, which was located in Scotland. The UKG contracted the facility with the aim of creating critical infrastructure to support the response to Covid-19 and any other future national medical emergency. A second contract was awarded by the UKG which was intended to fund manufacture of a Covid-19 vaccine. However, in September 2021 the UK Government cancelled its vaccine purchase contract and stopped all funding for the facility and vaccine development. As already referenced, this was bitterly disappointing as the Scottish Government and Scottish Enterprise had invested a significant amount of money into this development. It also provided high quality jobs and could have provided the UK with a future domestic supply chain of vaccines. I raised this directly with Sajid Javid, the UK Health Minister at the time and expressed my dismay.

Eligibility and prioritisation decisions

25. Although in Scotland the First Minister and myself were ultimately responsible for the vaccination policy, the eligibility and prioritisation, was primarily informed by JCVI advice and in almost every occasion we aligned with it. If I had any concerns about the advice, I would discuss these with the CMO, Dr Gregor Smith and his deputy, Dr Nicola Steedman. The JCVI advice formed the basis of four UK nations' decisions on vaccination and immunisation. However, the JCVI advice was often high level and afforded flexibility in how the vaccines were to be delivered. It is also important to note that unlike England and Wales, Scotland is not legally bound by JCVI advice, and it was, therefore, possible for us to make some decisions around cohort prioritisation and inclusion that were not explicitly stated within the JCVI advice. However, whilst accepting

the JCVI advice and being keen to align on a four nations basis, we did tailor the programme so the delivery approach was best suited to the needs of the Scottish population. But, as I have said, we did not significantly depart from the JCVI advice as we were mindful that we did not want to confuse the public about eligibility/ prioritisation of different cohorts, nor did we want to risk the public crossing the border hoping to subvert priority rules. Scottish Government clinical advisors liaised closely with JCVI and UKG officials. The process for determining eligibility and prioritisation did not significantly change during my time as Cabinet Secretary for Health and Social Care.

26. I attended regular online meetings and fora with UK Government Ministers and officials and there we would discuss vaccine eligibility and prioritisation amongst other things. My engagement with some UK Government Health Secretaries was more frequent than others. Most of my engagement with the UK Government was through formal meetings, usually arranged between private offices. However, on occasion, I would use informal messaging apps. Such messages have been provided to the Inquiry. In these meetings I would provide intelligence on the latest developments with Covid-19 in Scotland, and would represent, where necessary, Scottish Government interests or highlight concerns. We all seemed to understand that a consistent four nations approach was in the best interests of all. I always strived to maintain good and professional working relationships with UK and devolved Government counterparts. My experience of UK Government Ministers varied from individual to individual, but personally I would say I had a constructive working relationship with most of them. I understand that official-to-official engagement between Scottish Government officials and UK Government health officials was also good.

27. I also had very positive relationships with the other devolved administrations, particularly my counterpart in the Welsh Government, Eluned Morgan. We would often speak ahead of four nations calls to ensure that, as devolved nations, we were speaking in support of each other, where it was in our interests to do so. This often helped in our engagement with the UK Government. The positive working relationship with devolved counterparts was also important in order for us to share best practice where appropriate. For example, I recall speaking with Eluned Morgan about the vaccine roll out in Wales, when Wales was ahead of Scotland with the roll out of the vaccine, and similarly she sought feedback from me about what was working well in Scotland when we were making good progress with vaccines when Omicron emerged. There were particular challenges facing Northern Ireland, given Stormont had not been re-established, but I was able to work with them too on occasion.

28. Although generally, relations with Ministers in the UK Government were good, there were, naturally, some challenges and at times the UK Government seemed hesitant to share information. I recall one incident when the UK Health Secretary, Sajid Javid, messaged me concerned that Nicola Sturgeon was going to announce JCVI advice in relation to the vaccination of children, during one of her daily briefings. I made it clear that we would not be giving any specific details, but outlining the possible direction of travel, as was given. Transparency with the public was rooted in our approach to tackling the pandemic in Scotland. This caused a degree of friction at the time but was overcome through continued dialogue and relationship-building.
29. There was no deviation around “significant” decisions on eligibility and prioritisation. However, as detailed in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01) before I took over the role of Cabinet Secretary for Health, the Scottish Government had recognised early in the rollout that a process was required to consider issues around how JCVI advice was implemented in practice, and to also consider groups that weren’t explicitly covered in JCVI advice. Therefore, a Policy Panel group was established in March 2021 comprising clinical, policy, operational, and legal experts. This allowed holistic consideration of the merits of vaccinating specific cohorts, particularly where there was no explicit basis in JCVI advice to do so, provided [HY4/017 - INQ000244062] and [HY4/018 - INQ000243615]. Advice from the group would then be considered by either myself, or my predecessor, and a final decision taken. This is laid out in the Policy Panel Terms of Reference provided, [HY4/019 – INQ000376398]. Fuller details of this are provided in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01).
30. Basically, where there were suggested differences in approaches with the other UK nations it was usually due to Scotland’s unique remote, rural and island geography or down to the structure and governance of NHS Scotland which often differed to the NHS in other parts of the UK. Evidence was carefully considered by the programme’s Policy Panel which provided recommendations to Ministers. Exceptions were required for several reasons, including deployment considerations unique to Scotland and the country’s geography or the JCVI advice not aligning with the Scottish policy or legislative landscape. It should be noted that the differences noted below were relatively minor and on the whole, there was not significant deviation from a four nations approach on eligibility and prioritisation. Areas where there was divergence in Scotland included:

Island and Rural Communities

- Rural and remote health boards were allowed some operational flexibility in spring and summer 2021 to allow for “bundling” of vaccinations for these communities. This ensured Health Boards did not have to undertake multiple visits to these locations each time the programme extended the offer to new cohorts.

Unpaid Carers

- Unpaid carers were included in the JCVI under priority group 6, however, the definition of an adult unpaid carer in Scotland is broader than the JCVI advice. Scotland therefore offered vaccination to all unpaid carers and young carers aged 16 and over.

Prisoners and prison staff

- Scotland allowed for “bundled” vaccination of prisoners and prison staff in June 2021 to ensure Boards did not have to undertake multiple visits to prisons each time the programme extended the offer to new cohorts.

People with learning disabilities

- The JCVI advice recommended the vaccination of people with severe learning disabilities and those on the Learning Disability register. Due to differences in the way that people with learning disabilities are identified in Scotland (e.g. no learning disability register) the Scottish Government expanded JCVI priority group 6 to include people with mild or moderate learning/intellectual disabilities to ensure no one was excluded.

Seafarers

- The JCVI did not provide specific advice on vaccinating migrant seafarers. However, the vaccine was offered to migrant seafarers, including cruise liner staff, in Scotland. This included those registered as working or living in another part of the UK. Offering vaccinations to migrant seafarers was in line with the Scottish Government's ambitions to deliver an inclusive vaccination programme.

People in or entering residential drug and alcohol rehabilitation centres.

- Scotland extended JCVI priority group 6 to include such people due to their increased risks.

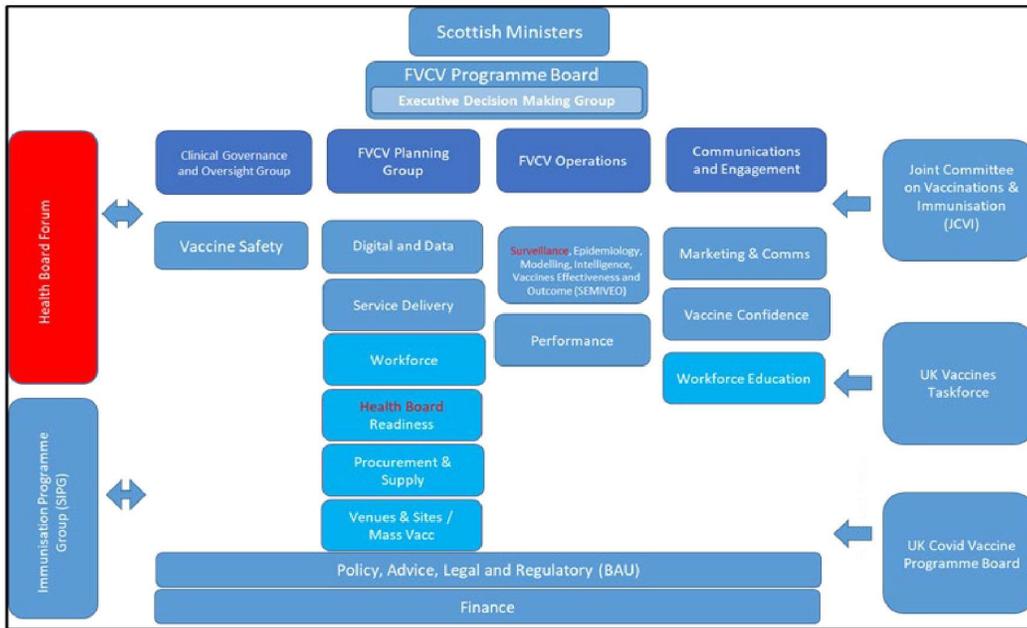
Covid -19 vaccination programme

31. By the time I entered office as Cabinet Secretary for Health in May 2021 there was a very good level of preparedness for vaccinating the population and there already existed a well-oiled machine administering the vaccination programme.

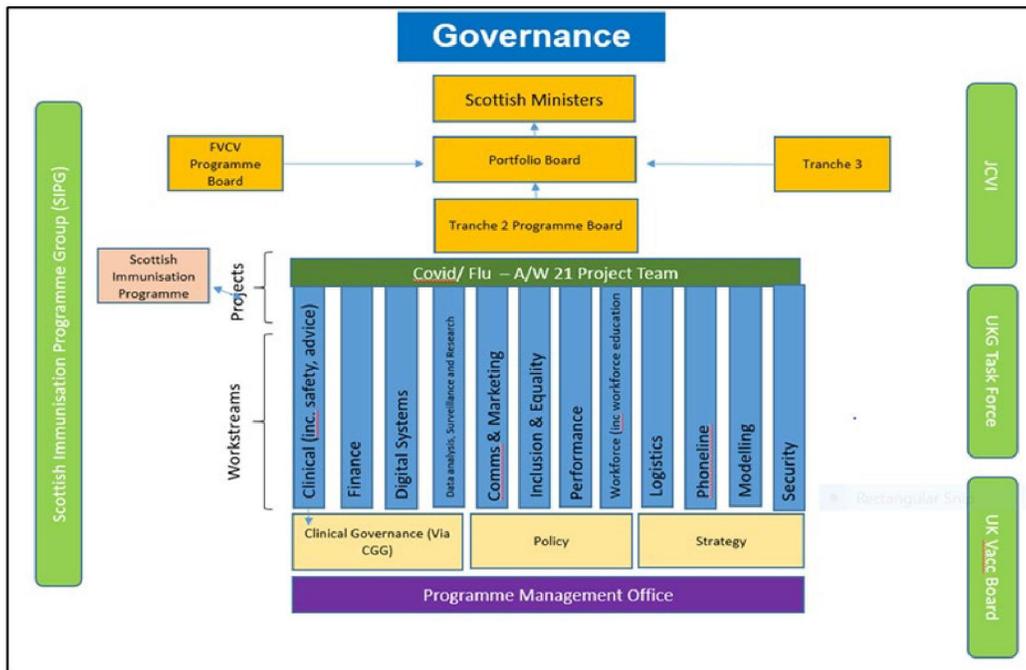
32. My role in respect of the rollout of the vaccination programme was to have national responsibility to ensure it was successful. To do this I had to work closely with a range of partners, primarily local Health Boards to ensure they had sufficient vaccine deployment plans in place, which included confirmation of adequate supply, ensuring suitable access to the vaccine programme for the population they were responsible for and ensuring adequate workforce was in place to meet the targeted rates of vaccinations. I had to have conversations with the UKG to ensure that Scotland had an adequate supply of vaccines; At a local level I had to ensure there were enough people to administer the vaccines and that vaccines centres were available where needed; I had to listen to and understand the challenges to vaccine access that I heard from both parliamentary colleagues but also members of the public; and I had to decide whether to align with JVCI advice and if not the reasons for such. I also signed off public messaging around the vaccine to try and encourage greater levels of uptake.

33. Before I took up office as Health Secretary, a decision was taken early in June 2020 to plan and prepare for the delivery of both the seasonal flu vaccine and a potential Covid-19 vaccine, provided [HY4/020 - INQ000261179]. The rationale for this was based on the impact seasonal flu could have if circulating alongside a peak of Covid-19 cases. On that basis the existing seasonal flu programme was brought into the governance structure for the FVCV programme in Scotland. In February 2021, a Vaccinations Directorate was established with a Vaccines Operational Policy division and Vaccine Strategy division, this was later in August 2022 merged back into the Directorate for Population Health as the Vaccinations Division.

34. This Vaccinations Directorate and later as the Vaccinations Division was the Scottish Government team responsible for the vaccination strategy. The initial FVCV structure is displayed below, showing the key groups and their interrelations under the FVCV Programme Board as the Executive Decision Making Group:



35. The governance structure was amended regularly in line with programme developments, in particular to include a Clinical Governance Group and a workstream with a focus on inclusion and equalities. This later iteration of the structure is shown below:



36. I regularly discussed the vaccines strategy with the vaccines team multiple times a week during the vaccines programme to tweak things if necessary (for example public

messaging). Alongside these meetings, Ministerial submissions were issued to either provide an update or seek decisions on issues relating to the FVCV programme. I also had conversations with the Health Boards to assess competing priorities. Generally, this was to ensure there was enough staff to deal with urgent care as well as giving priority to the vaccine programme. Scottish Government formed the strategy with input from the Health Boards. It was formed to ensure there was the most efficient operational delivery of the vaccine programme but also with an awareness that sometimes things would need to be adapted due to for instance remote or rural communities. The strategy was updated where necessary and appropriate. For example, if during the programme the run rate in a particular Health Board was too low, I would query this and seek assurances that adequate steps were being taken to rectify the situation, for example the Health Board in question increasing the vaccinator workforce or opening additional vaccination centres.

37. Once one iteration of the programme was over there would be a wash up session with the Vaccinations Directorate about what had worked and what had not and that would then be tweaked for the next iteration of the programme. Implementation was different seasonally, for example in the autumn /winter programme we would administer the Covid-19 vaccine with the flu vaccination, but in spring this would not be the case. Evaluation worked well here. Success of each iteration of the programme was measured by examining the data of people vaccinated and assessing whether targets set for vaccinating the population had been met.

38. As I have already referenced, I think interactions between the Scottish Government and the UKG and the Devolved Administrations on the whole worked well in relation to the vaccine programme. There were weekly four nations Ministerial meetings discussing a number of topics, vaccines included. Having had numerous interactions with the UK Government over approximately twelve years, in various ministerial roles, it is my view that vaccines in my opinion was an area where these interactions between the four nations worked best. Whenever issues were flagged by me or another devolved administration Health Secretaries, the UKG generally tried to accommodate us. There was an open channel of communication on vaccine issues, even where there may have been disagreement. As I said, I felt able to raise issues like the termination of Valneva contract with the UK Health Secretary directly and they in turn felt able to raise issues with me, for instance as previously mentioned, they raised concerns with me directly about the Scottish Government commenting on JVCI advice on the vaccination of children before this had been released to the public. I was able to reassure them that the

Scottish Government were always clear not to explicitly mention JVCI advice not yet in the public domain.

39. Information sharing at Ministerial and official level worked well between the four nations. Although operational decisions were the responsibility of each nation, information sharing as to what worked well and sharing best practice was invaluable. For example, I recall speaking with Welsh Health Secretary Eluned Morgan about the vaccine roll out in Wales, when Wales was ahead of Scotland with the roll out of the vaccine, and similarly she sought feedback from me about what was working well in Scotland when we were making good progress with vaccines when Omicron emerged. When we had issues with supply of vaccines it did expose some weakness in the exchange of information between UK Vaccines Taskforce and the Scottish Government. In spring and summer of 2021, supply issues began to impact the programme in Scotland, and often at very short notice. This was due to several factors including Astra Zeneca batch failing quality assurance and delays of stock arriving from India. Given the programme was operating close to a 'just in time' delivery model, the pause or disruption in vaccine supply, led to some appointments being cancelled and a requirement to reschedule appointments. However, this was improved by weekly supply meetings and sharing demand templates showing anticipated supply needs which were updated on an ongoing basis by all parties. Alongside these practical improvements I wrote publicly to the Secretary of State for Health and Social Care in June 2021 to seek assurances about efforts to resolve supply challenges, provided [HY4/021 - INQ000502205]. The Welsh Government supported this action as they had suffered similar problems. Initially the UKG were highly resistant to publishing vaccine supply information and indicated that contractual arrangements would make this impossible. However, both the Scottish Government and Welsh Government continued to push for a solution and with the permission of the manufacturers, a four nations approach to publish supply information was agreed.
40. The challenges around vaccine delivery in Scotland that I can recall are things such as geography, workforce and the availability of vaccination centres:
- Scottish geography – Because we have many remote, rural and island populations on occasion we had to adapt the programme to take account of these idiosyncrasies. We did this primarily by allowing "bundling" in phase 1 for certain hard to reach communities to allow all priority groups access at the same time. For example, when vaccinators went to small islands early in the programme, they vaccinated multiple

cohorts, even though in the main programme younger people were not yet being offered the vaccine.

- This allowed many individuals across a number of groups to all be vaccinated at once, so as to avoid frequent visits to certain areas. Also, GPs didn't routinely administer vaccines in Scotland (this was the Health Board's responsibility). But in some geographies (e.g. Argyll and Bute Health and Social Care Partnership NHS Highland) there was a request to allow island GPs to vaccinate. This variation was also agreed too.

- Workforce - With the resumption of health services (elective care, non-urgent care) it left us with a smaller workforce able to vaccinate. I would set out run rate target for population vaccination in each area and could see from the daily update on figures I received which Health Boards were struggling. It was ultimately for the Health Board to decide how to increase their workforce. This issue became particularly acute when new variant (Omicron) appeared, and the programme had to be accelerated and a significant increase in the workforce was required. Several steps were taken to assist Health Boards allowing them to increase their workforce. For example:
 - Opening up bank recruitment and simplify registration on bank for returners and students.
 - Follow up directly on offers to vaccinate for a new 'cleansed' list of offers.
 - Make contact proactively with the Universities to draw from 2nd & 3rd year local health care students.
 - Offer substantive staff overtime at substantive rates to promote workforce resilience.
 - Urgently communicate to all workforce that does not typically work during evenings and weekends to contribute hours to vaccination services.
 - Scottish Government took forward with NSS & NES to ensure that vaccinator posts were highlighted on job vacancy website.

- Availability of vaccination centres – Whilst mass vaccination centres were used in large urban city areas a different approach had to be taken in remote, rural and island areas (where one large centre wouldn't make sense). However, as society re-opened, it became more and more difficult to use large venues, such as Hampden Stadium and Glasgow Central Mosque for vaccination purposes. Organisations understandably wanted use of their facilities again as Covid restrictions loosened.

This challenge was overcome by negotiations/procurement of other venues for the sole purpose of vaccination. Also access to venues was not always easy for people who lived remotely, so we worked with Health Boards to ensure as wide coverage of centres as possible. Vaccination rates in remote, rural and island health board areas was often better than large urban health boards.

41. The only supply issues that I can recall are those of spring/summer 2021 as detailed in paragraph 39 above.
42. I consider the vaccine deployment programme was very efficient. In Scotland the percentage of vaccine wastage was very low – just over 2% (well below the 5% modelling assumption). I monitored these figures on wastage via regular updates from my officials. The figures and percentage rates of vaccine wastage were also published in the Public Health Scotland weekly respiratory report. I consider this degree of success was primarily obtained due to the high uptake percentage of vaccine overall, (although, I do of course accept there were certain groups that did concern us with the reluctance to be vaccinated.) Also, the CPO provided written best practice guidelines to the NHS to help them minimise risk of unnecessary waste from Covid-19 vaccine administration.
43. I cannot recall any significant issue being brought to my attention around distribution of the vaccine to any particular location. I think there may have been a few challenges prior to my appointment e.g. the temperature controls required for the Pfizer vaccine which caused some challenges to remote, rural island communities in Scotland. There was an agreed formula with UKG about the amount of vaccine Scotland would receive. And conversations were held with the Health Boards to ensure there was fair distribution amongst them.
44. On the whole, I consider our vaccination deployment programme was very successful. There is no doubt from the evidence available that the vaccine helped to save lives. A World Health Organisation (WHO) published paper on the vaccination programme in Europe, estimates that over 22,000 lives were saved in Scotland due to the vaccine, the paper goes on to estimate that in Scotland around 70% of deaths have been averted among those over 25 years old as a direct result of the vaccination programme, provided [HY4/022 - INQ000502208]. Clearly decisions on prioritisation and eligibility did impact on deployment, however, it was right that these decisions were made to ensure the maximum impact of the vaccine in preventing the worst harm to those most at risk. The emergence of the Omicron variant in October 2021 and the potential for increased social

interaction over the festive period in 2021 led to more targeted communications and marketing. The later phases of the programme, with a more complex and focused offer, called for a more nuanced approach. Any decisions on eligibility or prioritisation were only made after ministers had taken advice both from the JVCI and our clinicians.

45. Where necessary, I could push back on this advice and I did question/ raise concerns on a number of occasions, I recall. Concerns were raised about the administration of vaccines to children in Sept 2021, and questions were asked whether the rollout of the vaccination programme could begin sooner. I had conversations with Dr Nicola Steedman, the DCMO about expediting steps involved in the roll out programme and was advised where this was possible (or not). I recall that dosing intervals impacted on the deployment programme (clearly, shorter intervals meant the programme could be completed quicker). However, this was always for clinicians to provide advice on whether this was acceptable, possible and for whom.
46. Vaccination workforce of course was a significant limiting factor in the run-rate of the programme. Whereas primary care workers (e.g. dentists and optometrists) were used in early stages of pandemic, as restrictions eased and society re-opened these primary care workers returned to their own profession and to tackle the backlogs in their own areas of specialty. The decision was then taken to create a bespoke vaccination workforce. This was a more sustainable and resilient approach to vaccination workforce level.
47. Regular data was presented to me on the uptake of vaccination, the supply of the vaccine, and levels of workforce engaged in administering the vaccine. I think the data provided was sufficient, appropriate and timeous for decision making purposes. Amongst other things this data provided information on where the uptake was lower (e.g. amongst certain ethnic groups and in areas of high deprivation). For instance, information started to be collected from people attending for vaccine appointments in late 2021 on ethnic groups. With hindsight, I think if this data had been collected from the beginning of the programme then health messaging and deployment of the vaccine could have been adapted earlier. Anecdotal data from those on the ground (midwives) was also received that uptake was lower among pregnant women. In light of this data/information our public messaging was adapted, we used community figures where possible (e.g. ethnic minority doctors) speaking a variety of languages to encourage vaccine uptake amongst diverse communities. Specific messaging was adapted towards pregnant women

regarding safety of unborn children, and we used pregnant women, new mothers and midwives to spread this message, tailoring the messaging accordingly.

48. Rates of people who did not attend or show up for their vaccine appointment was also captured as data. However, it should be borne in mind this should not necessarily be considered as “refusal”, as vaccination was optional. It was not a legal stipulation. I recall there were regular social attitude surveys during pandemic, with questions about the efficacy of vaccines. Accordingly, we regularly engaged with Steven Reicher (a behavioural psychologist and expert) to help us understand more about vaccine fatigue and hesitancy, and to try and target those who didn’t believe in vaccine efficacy.
49. The technology we used to collect and review data worked well and I certainly did not feel there was a lack of data. I suspect we possibly could have used technology sooner as part of the vaccine programme, for instance the digital platform to book appointments introduced later in the programme could have been brought in earlier, whether this would have made a difference in overall uptake numbers is difficult to answer. The Scottish Government believed in the importance of transparency and accordingly published as much data as possible. We were careful to caveat data appropriately if it was management data and had not gone through all of the rigorous verification required of official statistics. In addition, there can be times when data is not published due to appropriate commercial reasons, however, we would always seek to find a way to publish data if at all possible. For instance, vaccine uptake figures were published almost immediately. And there were regular calls from opposition MSPs in parliament/media to publish all sorts of data, which we sought to do whenever this was possible.
50. In developing our vaccine strategy, we gave a lot of consideration to socio-economic determinants, marginalised or vulnerable groups and communities. A lot of tailored work was undertaken with a wide range of stakeholders to ensure our delivery model for the vaccine suited a broad range of different community needs. For instance:

Homeless

- The decision was made to include homeless people in priority group 6 due to their poorer health outcomes generally and reduced access to healthcare. We worked with homeless organisations and known and trusted support workers in night shelters and emergency accommodation to try and reach and support these people.

Those for whom English is not a first language

- There were good processes already place for vaccination of this group prior to Covid-19 – these processes were incorporated into the Covid vaccination programme. For example:
 - Appointment letters had QR codes which allowed the individual to access range of languages.
 - Translators could be requested for the vaccination appointment.
 - Family members could attend the appointment to translate.
 - Held mobile clinics in range of religious and community settings.
 - Used ethnic minority media channels (e.g. radio).
 - Worked with organisations such as Scottish refugee council.

Those with unconfirmed immigration status

- Work here was undertaken with PHS and with Scottish Refugee Council to develop a 'Statement of Facts' on the Covid-19 vaccine, which was translated in to five languages. It covered information pertinent to these communities, including the vaccine approvals process, ingredients and confirming that no personal information would be passed to the Home Office in relation to immigration status. We also felt it was important to confirm to those in the asylum process that no personal info would be passed to Home Office regarding immigration status.

Disabled people

- The Scottish Government worked with disability charities and representative groups e.g. Glasgow disability alliance and the vaccine steering group, to better understand the concerns and needs of those with disabilities. I think strong relationships were put in place at policy level and any specific concerns fed back to me. Vaccine materials were produced in braille and British Sign Language. Adaptations were made at vaccination sites e.g. vaccine info produced in brail, sign language interpretation available at clinics when required, wheelchair access.

The clinically vulnerable/immunosuppressed

- The definition of “clinically extremely vulnerable” was decided in unison by the four nations CMOs at the beginning of the pandemic. The approach to further develop the list of people who were at highest risk did vary slightly between the Scottish Government and other rest of the four-nations because we didn't use the same systems. Further information on this group and our treatment of them can be found in the Module 2-2A DG Health and Social Care statement (INQ000215487) at

paragraphs 451-453. I think it was apparent and well accepted by the public as to why this group was given vaccine priority.

Prisoners and those in state detention

- As prisons are environments which lend themselves to high transmissibility of virus, Scottish Government officials made plans to ensure efforts were made to promote high vaccine uptake in prisons. Health Boards were asked to encourage prisoner uptake in their Inclusion Plans. The National Clinical Director (NCD) attended HMP Barlinnie for a Q&A session with prisoners which was available via prison radio and TV. He also recorded prison radio messages to encourage continued uptake and address any concerns. There was also the development of a prisoner letter “door-drop” similar to the national one for the rest of the population; tailored posters; and leaflets detailing how to get your second or booster dose when released. The recommendation was also made in June 2021 to “bundle” all unvaccinated age groups of prisoners, so that they could all be vaccinated at the same time.

51. Behavioural experts advised us that people were likely to accept decisions more easily if Governments were transparent about the logic and rationale behind them. Therefore, we ensured the public had access to data in relation to the vaccine and were aware of the decisions we made in relation to the deployment programme, its implementation and challenges by publishing all information that could be published, (e.g. vaccine uptake figures were available within a few days of the first vaccinations taking place.) An example of where that transparency of decision making was particularly important was in relation to vaccinating young people, and children in particular. That is why the Scottish Government took the decision to publish CMO advice on our decision to vaccinate children. This was particularly important as there was a level of public awareness in relation to side effects of the vaccine amongst children, these were rarely serious, but in some cases myocarditis and pericarditis had been found to present as side effects amongst children. We gave daily briefings where the FM would generally be joined by either the CMO or the National Clinical Director. As well as providing a factual update, the daily briefings also allowed for questions to be answered from journalists. We had proactive messaging campaigns e.g. ‘roll up your sleeves’. These were often targeted at a particular cohort (e.g. students, pregnant women, hesitants) - this was done either through the messaging itself or the way in which it was delivered e.g. via social media. Fuller details of these campaigns are provided in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01) - paragraphs 219-225.

52. I think that on the whole there was sufficient support from government to hospitals, GP practices, pharmacies and other vaccination organisations notwithstanding rate limiting factors such as staffing levels (given that the system was already under pressure); vaccine supply (this was primarily an issue in the early days); and physical space (being able to secure appropriate space for centres given the IPC restrictions that had to be in place).
53. The Scottish Government worked with partners to stand up the extended flu and Covid-19 vaccine programme (FVCV) which provided governance to support the planning and delivery of the Covid-19 vaccine rollout. The FVCV programme supported vaccine delivery partners through a range of different measures including:
- The development of national digital systems for vaccinators and health board staff to record Covid-19 vaccine events and to support Boards with national appointment scheduling.
 - The development of a national online booking system for the public to book and rearrange appointments.
 - Working with NSS to set up a National Vaccine Helpline for the public to book and rearrange appointments.
 - Consequential funding used by the Programme to support Boards with costs incurred in delivering the vaccine.
 - The development and dissemination of a range of guidance documents for delivery partners.
 - Working with UKG MoD through a Military Aid to Civil Authorities Agreement (MACA) to deploy military logistical planning, site set-up and vaccinator teams, like other parts of the UK to support with the vaccine workforce during periods of acceleration.
 - The development and delivery of national marketing campaigns for the Covid-19 vaccine, including a range of stakeholder tools and resources, many aimed at supporting under-served communities.

- Working with the British Red Cross to match volunteers through the National Volunteer Coordination Hub to support at vaccine clinics.
- The funding of the Scottish Ambulance Service to deploy mobile vaccine units to underserved communities in rural and remote communities.
- Financial support was given to employers of health and social care staff so they could receive booster jabs without having to sacrifice paid hours or annual leave days.

54. I can't comment in detail on the beginning of the programme, but certainly from my time in post (May 2021 onwards), organisations and individual stakeholders were invited to input into policy and strategy for the vaccine deployment programme and its implementation. Overall, the views of organisations, clinical staff, health and social care staff and local government colleagues were incredibly important to the successful delivery of the vaccine. These views were used in a number of ways:

- It was the responsibility of local health boards to deliver vaccines to populations (with oversight from the Scottish Government's flu and vaccines team)
- Health boards were empowered to use approaches best suited to their particular area (e.g. the approach taken in Orkney would perhaps be different from Glasgow and Clyde).
- The input of local clinical and care staff in those areas of hugely significant value to this approach.
- Given that there was lower uptake of vaccine among certain groups (e.g. certain ethnicities, religions, lower socio economic, homeless) input from local organisations representing these demographics, particularly regarding data, was also hugely important.
- Due to the fragmented nature of social care landscape (a mixture of local authority and private providers), it was necessary to have strong relationships with individuals and organisations representing the care sector and local government.

- The input of individuals and organisations was hugely important for public messaging around vaccine deployment.
 - Trusted voices (e.g. clinicians/community voices) were utilised to remind people of the importance and efficacy of vaccine uptake, particularly with follow up doses, second doses and boosters.
55. It is also the case that my regular updates with trade unions and professional bodies would allow issues of vaccine deployment to be raised, and if appropriate, inputted into any future iteration of the strategy.
56. I am not aware of any particular aspects of stakeholder advice not being taken forward. Although some non-health and social care groups advocated for their members to have priority access to vaccination based on their occupation and often made representation to officials and politicians on that basis. This included key workers who perceived themselves to be at higher risk of infection, such as teachers, other blue-light services including the police, the prison service and those in critical infrastructure roles. Due to this and given the likely limited supply, the policy team's approach was to focus on the JCVI's interim guidance, aimed at reducing severe illness and vaccine-preventable death from the virus. The Scottish Government concluded that the clinical risk of these groups lobbying for inclusion was not increased due to their occupation, therefore, they were not initially included in the priority access groups. This also ensured a consistency of approach across the four nations.
57. Ultimately, I think the Covid-19 vaccine deployment programme was hugely effective and one of the most successful aspects of our strategy to tackle the virus. As evidenced by the World Health Organisation (WHO) study which found that between December 2020 and November 2021, an estimated 27,656 deaths were directly averted as a result of the Covid-19 vaccination programme in Scotland, provided [HY4/022 – - INQ000502208]. This study was originally published in November 2021, however, the data has since been updated and in January 2024 the report was republished to confirm an estimated 22,138 lives in Scotland were saved as a direct result of the Covid-19 vaccination programme between December 2020 and March 2023, provided [HY4/023 - INQ000502209]. Also, at the point of the 'Boosted by the bells' campaign Scotland had one of the fastest vaccination programmes in the world. All of this ultimately demonstrates the effectiveness of the programme.

58. However, having said that, whilst I maintained overall national strategic responsibility, Health Boards had day-to-day operational responsibility. There were a number of occasions during the programme when I would challenge Health Boards on speed of delivery or operational decisions made at local level, such as decisions to close vaccination centres or for example, if I received feedback that there were lengthy queues at a particular centre I would question if there were enough vaccinators in place. I also had conversations with Clinicians in order to ascertain whether a vaccine deployment could be commenced sooner, or if we had any flexibility around particular processes related to deployment.
59. For example, when JCVI advice was provided in relation to a universal roll out of the vaccine for all 16 and 17 year olds, I had a conversation with the Deputy CMO Nicola Steedman in relation to how quickly we could get the programme up and running. Could certain processes like Patient Group Directives, necessary written instructions for vaccinators, be sped up without compromising in any way the safety of the vaccine deployment programme. I encouraged clinicians to go through necessary steps as fast as possible and as was appropriate, so deployment could commence as quickly as possible to increase effectiveness of programme.
60. Some individuals and organisations did raise concerns regarding the Covid-19 vaccine deployment programme. There were concerns raised by a range of groups representing people from diverse ethnic and religious backgrounds, and also those from a lower socio-economic status, or homeless backgrounds. Specific actions were taken to address their concerns as best as possible (e.g. mobile vaccination units being deployed and tailored messaging towards certain demographics). We also received regular representations by Rural and Island communities via their MSPs in the Scottish Parliament, complaints that constituents would have to travel large distances to get vaccinated. I accept that in hindsight, the model deployed, and the use of GPs could have been more flexible to avoid this issue of significant journeys for some. Some concerns were raised directly with me for instance, Fergus Ewing MSP raised problems facing remote and rural communities with me directly, such as issues regarding scheduling patients at far away clinics. Also, representative groups such as BEMIS directly engaged with me, they raised a number of concerns including, but not limited to:
- Scepticism of Home Office messaging. There was a severe lack of trust in government by migrants and asylum seekers related to Home Office scepticism of asylum claims – these groups feel marginalised and not listened to. There were

concerns that any information provided to vaccinators could be passed on to the Home Office and used against them in their case for asylum.

- Webinars were organised with the Gypsy/Traveller community to provide information on the vaccine programme and to answer questions and address particular concerns they had.
- There was a feeling amongst many in the Scottish-Pakistani community that they had been hit particularly hard by Covid and given their extended family networks there was a stigma attached to covid as they have been labelled as super spreaders.

61. I also received correspondence from members of the public raising legitimate concerns around the vaccine (such as, impacts of side effects and whether these were appropriately recorded on the yellow card system). The issue of cohort prioritisation was also raised with me, individuals and MSPs raised the issue of perceived “queue jumping”. This would be investigated, and it was found often it could be justified and understood in rural/remote/island communities where it didn't make sense to make multiple return trips. However, far too often for my liking there was also administrative errors in the system, when these were flagged they were investigated by the local health board and usually fairly quickly rectified.

Public messaging in respect of Covid -19 vaccines

62. I had a number of different roles in relation to Covid-19 vaccine public messaging. Most obviously, I was often the public face, from the Scottish Government disseminating our messaging around vaccines, and answering questions in relation to the vaccine programme. I gave multiple media interviews-before a vaccination programme began, during the programme and between programmes. I occasionally accompanied the FM on daily media briefings. I ensured the media were in attendance when I had my own vaccination and used the opportunity to talk about the importance of vaccination. I also had strategic oversight of our vaccine programme messaging. While there was a comms team in Government tasked with messaging in relation to the pandemic, including vaccines, Ministers gave strategic oversight.

63. The ultimate aim of the public messaging was to encourage as many eligible people as possible to take up the offer of a vaccine. The aim evolved depending on the time and the demographics targeted. For example, Winter messaging was tweaked to remind

people to protect the NHS during busy times when there were more interactions during the Christmas period. Different languages were used for ethnic minorities, social media influencers were used to target young people etc. There was a broader team involved in comms and where they required strategic decision making around public messaging (e.g. where there was to be a fundamental shift/particular targeting). This was raised with me, and approval sought where necessary. Small tweaks to the messaging didn't need ministerial approval. Budget was of course a consideration that informed decision making regarding messaging, but I would not say it was a significant limiting factor.

64. Public messaging and misinformation were not specifically discussed in Ministerial meetings with the UK Government, Welsh Government and Northern Ireland Executive but was of course touched upon in the sidelines.
65. I would have to conclude that public messaging in Scotland was very effective and the methods for assessing and monitoring effectiveness were sufficient. Further details of public messaging are provided in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01). Whilst there was a dip in uptake as years went on, the overall levels of uptake for the Covid-19 vaccination remained high. I believe public messaging played a role here, this could be said to be evidence of its effectiveness. Messaging campaigns were regularly evaluated in relation to their reach and broader effectiveness. Our Communications team worked closely with Health Boards to develop messaging that would support them to reach those being called forward at each stage of the vaccination programme. The use of social media assets was monitored throughout and regularly discussed and revised messaging to ensure these were utilised and effective for their audiences.
- 63 Website analytics were used to understand how the public were accessing NHS Inform. Days with spikes from particular platforms allowed us to evaluate which social media platforms were most effective at reaching the public and where campaigns had been particularly effective at encouraging people to visit NHS Inform. Marketing campaigns were independently evaluated for their reach and impact on the target audience. Evaluation reports were undertaken by Progressive who were appointed from the Marketing Services framework to undertake the independent evaluation of health campaigns, which includes the Covid-19 vaccine activity. Further details of these reports are provided in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01)

64. I was always mindful of vaccine fatigue, vaccine hesitancy and misinformation and disinformation being spread, particularly across social media. Our public messaging evolved to address these issues. For example, there was evidence from clinicians that pregnant women were hesitant to be vaccinated and had concerns (despite medical advice that vaccine was safe to take). Therefore, specific material was deployed for pregnant women in response to this. A leaflet and video were developed that included voices of pregnant women, midwives and other trusted voices. Trusted voices were used, such as social media influencers, to encourage young people who were eligible to take the vaccine. When we had issues around the types of vaccine being used (Astra Zeneca vs Pfizer) we were keen that people should not get into the habit of being able to pick and choose which vaccine they had as this could cause supply issues. Those issuing the vaccine were equipped with responses that all vaccines offered were effective and for the vast, overwhelming majority there was only mild side-effects. We ensured vaccinators were well trained and educated and had answers to all on common questions from public about the vaccine. I strongly believe transparency was the antidote to vaccine hesitancy. However, I also understood that some people were so opposed to receiving the vaccination that they would never get vaccinated and so a 100% vaccination target would be impossible to meet.
65. I believe the public communication was appropriately timed, accessible, linguistically appropriate and culturally sensitive. I found the feedback loop from stakeholders very useful – conversations could be had with various people and organisations representing different demographics, these largely took place online due to restrictions in place. This allowed us to disseminate messages from government with relative speed and ease. At all times, the Scottish Government strived to ensure our public messaging was factually accurate, honest, open and applicable and available to all. As outlined in the Module 4 DG Health and Social Care Corporate statement (reference M4SG01) our national communications plan included the production of translated assets in a range of community languages and British Sign Language (BSL). The information was developed in multiple languages on NHS Inform, with accessible formats also available such as Braille, Easy Read, large print and audio.
66. The Scottish Government worked with PHS to create translated versions of the 'What to Expect at a Large Vaccination Site – Louisa Jordan Walkthrough Video' and a 'Smaller Vaccination Walkthrough Video' in seven community languages. This was shared with

ethnic minority stakeholders and Health Boards and distributed via Equalities Policy colleagues. Individual Health Boards developed local versions for use through their own social media channels.

67. A Ramadan film was created in partnership with the British Islamic Medical Association and launched in April 2021. This video was to reassure Muslims who were concerned about getting the vaccine while fasting and was created in multiple languages. The Ramadan film was included in a toolkit addressing hesitancy in the Pakistani community which had assets translated into Urdu.
68. A toolkit specifically created for ethnic minority communities as part of the “Roll Up Your Sleeves” was created and launched in April 2021. This included bespoke assets and messaging that addressed particular concerns amongst ethnic minority groups, and included suggested social media posts which signpost to the language-specific pages that PHS have created on NHS Inform. We also worked with BEMIS and the Ethnic Minority National Resilience Network (EMNRN) to gather feedback from Ethnic Minority organisations and to help shape communications, which has influenced messaging and available formats. The EMNRN was launched by BEMIS to enable Scotland’s ethnic minority communities to support each other throughout Covid-19 pandemic. We also worked with NHS Lothian’s Minority Ethnic Health Inclusion Service (MEHIS), who input to the content specifically to address barriers to uptake for Scotland’s South Asian community. MEHIS shared campaign assets with community outreach officers who engage with members of the community, both virtually and face-to-face.
69. Furthermore, the Scottish Government worked with the Scottish Public Health Network (ScotPHN) to provide the Covid-19 vaccines national mailing directly to Gypsy/Traveller communities across Scotland, which were distributed via site managers. The NCD took part in a Q&A session hosted by FENIKS for the Polish community on 6 June 2021 and a live streamed radio interview with Jambo! Radio which serves African and Caribbean communities.
70. I think public messaging was adapted appropriately and in a timely manner with evolving advice for particular groups. For example, I have referred to how this was done for pregnant women above. When it became known that there were side effects from the vaccine amongst a small percentage of children i.e. myocarditis and pericarditis, we ensured clinical voices spoke out publicly on this concern at the time to reassure parents. For students we deployed marketing assets in advance of academic year

starting. Scottish Government marketing and communications colleagues worked with Public Health Scotland to develop a range of different resources and communications during the pandemic targeted towards students. The main campaigns consisted of:

- a student vaccination toolkit launched in July 2021.
- a substantive paid-for campaign (budget of £95,000) in August/September 2021 consisting of creative assets, and associated media buying plan, for encouraging students attending college or university to get the Covid-19 vaccine.
- The campaign activity was delivered with five weeks of paid-for digital advertising across social media channels. This included adverts on TikTok, Instagram, Snapchat and Facebook. It was supported with organic activity delivered by stakeholder partners: National Union of Students Scotland (NUS Scotland), Universities Scotland and Colleges Scotland, as well as by Colleges and Universities themselves, who were involved in the development of the campaign strategy. We provided all partners with a toolkit of materials and messages which they utilised across their own communication channels.

Vaccination as a Condition of Deployment

71. When the idea of making vaccination a condition of employment for health and social care staff was first mooted, I took advice from officials, legal and clinical advisers. I received a submission on 15 July 2021, provided [HY4/024 - INQ000240381], it outlined a proposal of making Covid-19 Vaccinations a Condition of Employment for NHS Scotland staff. Policy colleagues confirmed that it would be a significant departure from the then health policy and there was the potential for legal challenges, given the possible human rights infringements. Also, consideration of the potential disproportionate impact on staff from particular demographics where uptakes rates were not as high, had to be taken into consideration.
72. Engagement with employers, trade unions and professional organisations in Scotland indicated significant opposition to any such policy being implemented. This also needed to be considered in light of the views of trade unions in relation to proposals to relax the rules on self-isolation for NHS staff to maintain service delivery. Strong opposition was voiced to this, or any policy that appeared to contradict public health messaging and

resulted in health and social care workers being treated differently to the public or other workforces.

73. Regulatory Bodies assessed each case individually on its own merits, in the prevailing context at the time. Scottish Social Services Council (SSSC) feedback was that it would be likely to take failure to comply with mandatory vaccination seriously, particularly where there is an impact on the safety of patients. In this context, refusal to be vaccinated could be considered as a refusal of a reasonable management request and the consequences could be disciplinary, regulatory, or both. There were however concerns on how this could be enforced, in particular, whether any form of penalty could be deemed as proportionate. There were also concerns around the impact on services, where redeployment of staff who decline to be vaccinated, to non-frontline roles would be difficult and could cause disruption. In addition, as part of the public health and social care workforce is self-employed (e.g. many GPs who also visit care homes) it is likely that a duty to take reasonable steps to ensure that their workforce was vaccinated would place that obligation on the individual worker.
74. We recognised at the time that the approach to staff who refused to be vaccinated needed to be balanced with resident and patient safety and public confidence. The complex considerations on proportionality, human rights, and impact on services were likely to mean that the Regulations would be subject to legal challenge and ongoing criticism. The Scottish Government took into account the fact that some people will be vaccine hesitant, whether mandatory or not. Getting the support of staff for any policy aim was also a key consideration.
75. We considered that any such Regulations would be controversial and could have been challenged under ECHR, specifically (but not exclusively), Article 8 (right to family and private life) and Article 9 (right to freedom of thought, conscience and religion). The policy to mandate the vaccination of all care home workers was also unprecedented. It was also important to note that the Covid-19 vaccines had not been fully licensed and that could also result in legal challenge. Professor Sir Gregor Smith, CMO, remained of the view that there were significant ethical challenges in mandating a vaccine that is known not to be 100% effective and in the case of Astra Zeneca, can have an adverse effect profile that includes significant adverse effects, such as clotting, albeit in a very low level of cases. It also goes against the principle of informed consent and runs contrary to the values advocated within Realistic Medicine. There was also the question of whether mandatory vaccination is a proportionate means of achieving a legitimate aim.

76. Ultimately, I concluded that vaccination would not be made a condition for employment for a variety of reasons, as outlined above. In addition, I also did not feel it was required and necessary as the level of vaccine uptake for health and social care staff was generally very high as detailed in the table sourced from Public Health Scotland below:

Covid-19 vaccine uptake to September 2022

Group	Dose 1	Dose 2	Booster
Any Health and Social Care Worker	94.5%	92.9%	82.8%
Specific frontline health and social care workers	96.8%	95.7%	89.4%
Social Care workers	93.1%	91.1%	78.5%

77. I did not have substantial detailed discussions with other UK or Devolved Government colleagues. While the issue was raised, devolved decision making in this area was respected with no attempt to force a four-nations approach, certainly not at Ministerial level.

Barriers to vaccine uptake

78. My understanding was that levels of public confidence in Covid-19 vaccines were high in Scotland, this was clearly evident from high uptake figures (particularly in comparison to other vaccination programmes). Various feedback loops were important to gauge levels of confidence in the vaccine, and this feedback came from various avenues. Direct engagement with communities and also with local and representative organisations was critical to understanding and addressing any issues of hesitancy, fatigue or mistrust. The Scottish Government recognised the importance of engaging with those groups representing communities who were experiencing barriers. This was in acknowledgement of the fact that certain communities had relatively higher levels of mistrust in Government, therefore partnership working was important to ensure vaccination was accessible to everyone. The Vaccine Inclusive Steering Group was essential in seeking feedback on any issues related to vaccine hesitancy and mistrust. Membership of this group comprised of third sector, faith and community groups, representatives of ethnic minority groups as well as Health Board Equalities Leads and Deep End GPs (Deep End GPs are a group of GPs who are located in the areas of highest deprivation in Scotland). We also commissioned data from polling companies on the vaccine, and also social research to better understand barriers to vaccination. We

tried to engage widely and directly with those who had concerns about getting vaccinated in order to understand the reasons for their hesitancy. The statement from the Module 4 DG Health and Social Care Corporate statement (reference M4SG01) provides further details of this.

79. Work was done to combat deliberate disinformation by ensuring vaccinators were well informed, we had proactive rebuttals of disinformation and we used trusted voices on social media (influencers with a large following).
80. Hesitancy was a greater concern than disinformation. Here we had to work out what the barriers were and how to remove them. Examples of removing barriers included ensuring ease of access to the vaccine via mobile units, and that there were enough centres open in rural communities.
81. During my time as Cabinet Secretary for Health and Social Care some of the steps I took to encourage vaccine uptake were as follows:
 - I undertook regular media appearances to encourage vaccine uptake and used the profile of my office to encourage uptake.
 - I undertook direct engagement with various demographic groups.
 - I oversaw marketing assets to encourage uptake.
 - I made decisions to ensuring we had an adequate supply of mobile vaccination assets and promoted this via media appearances (e.g. attending the vaccination bus at Hampden Stadium).
 - I was a prolific user use of social media and used it to regularly encourage vaccine uptake.
 - I ensured vaccination was accessible at a strategic level – e.g. ensuring there was sufficient work staff, vaccine centres, supply from UKG etc.
82. The marketing campaigns I oversaw were as follows:

Roll up Your Sleeves – 2

- 16-17 year old (older activity) 13th Aug 2021 – 29th Aug 2021
- 16-17 year old (older activity) 29th Nov 2021 – 16th Dec 2021
- Parents of 12-15s – 20th Sep – 10th Oct 2021
- Pregnant (paid social only) 8th – 21st Nov 2021
- Health Boards drop in clinics digital only 14th-20th Jul 2021
- Health Boards drop in clinics Radio & Digital 1st – 12th Sep 2021
- Student Vaccination 20th Sept 2021 – 16th Sep 2021
- Hesitants radio 15th Jul – 8th Aug 2021
- Hesitants 7th Jul – 10th Aug 2021
- Hesitants 6th – 19th Sep 2021.

Booster

- 27th Sept 2021 – 6th Feb 2022 inc extension
- Health Boards Booster 15th Dec 2021 – 9th Jan 2022
- 16-17s 13th-27th Jan 2022
- Pregnant Hesitants 17th – 30th Jan 2022
- Hesitants- 'Take it from me' - 7th Feb 2022 – 27th Mar 2022
- Parents of 5-11s - 15th -31st Mar 2022
- Pregnant & Fertility advertorials - 21st Feb 2022 – 27th Mar 2022.

Don't Let Your Protection Fade Co-vax (Flu and Covid-19)

- 10th Oct - 4th Dec 2022.

Don't Let Your Protection Fade Co-vax (Flu and Covid-19)

- 4th Sep – 30th Oct 2023.

83. As previously referenced, evaluation of marketing campaigns took place. We could also judge the effectiveness of such interventions by the high levels of vaccine uptake, particularly in comparison to other vaccination programmes.

Marketing spend 2020 to 2021

Total Covid-19 Pandemic Response - £20,594,464
(Vaccine Spend £290,258)

Advertising, Digital, PR, Field, Research	Media	TOTAL
£3,666,682.87 (Vaccine: £25,593)	£16,927,782.28 (Vaccine:£264,664)	£20,594,464 (£290,258)

Marketing spend 2021 to 2022

Total Covid-19 Pandemic Response - £11,913,161.22

Advertising, Digital, PR, Field, Research	Media	TOTAL
£1,728,240	£10,184,920	£11,913,161

84. I cannot think of anything further that ought to have been implemented to encourage vaccine uptake.
85. I think to an extent lower vaccine uptake and disparities within particular communities (ethnic/religious/homeless) may have been foreseeable prior to the start of vaccination roll-out if the data from previous vaccinations and public health interventions had been examined at in the beginning of the programme. To have not asked the question of ethnicity in other vaccination programmes, prior to the pandemic, is in my view a missed opportunity to collect better and far richer data. This could then have informed us of the likely hesitancy issues we clearly saw amongst some ethnic minority groups, and as a result ensured assets were in place at the beginning of the vaccination programme to help increase uptake levels.
86. With regards to encouraging uptake in the light of mis/disinformation, I think it is hard to predict what the nature and level of such disinformation will be, what conspiracy theories will take hold or not, and therefore proactively countering disinformation can be challenging.

Misinformation and Disinformation

87. I have touched upon how I and the Scottish Government tended to handle and respond to mis/disinformation in relation to the Covid-19 vaccines. I ensured we used our marketing assets appropriately, we had proactive media messaging, and reactive messaging where and when necessary. I also ensured that the vaccinators were well

equipped with the answers to common issues raised and the information required to counter the false and damaging stories and information often online about the vaccine. In my view, the First Minister's daily briefings were invaluable in countering any disinformation that could be flushed out in response to journalists' questions.

88. I would say that the steps we took to counter vaccine misinformation and disinformation in Scotland were adequate and this is reflected in the high uptake here of the vaccine. At all times we strived to ensure all information material on vaccines were factually accurate, honest and open. For instance, for pregnant and breastfeeding women Public Health Scotland prepared a Health Inequalities Impact Assessment for the Covid-19 vaccine programme in November 2020 which covered operational considerations around vaccinating pregnancy and maternity cohorts is provided [HY4/025 - INQ000502210].
89. Scottish Government FVCV policy colleagues undertook an Equality Impact Assessment (EQIA) for the FVCV programme for 2021/2022 which considered the JCVI advice and Scottish Government policy position on evidence and eligibility for pregnancy and breastfeeding for the Covid-19 and flu vaccine and is provided, [HY4/026 – INQ000502211].
90. Another EQIA for the 2022/23 FVCV programme was prepared which covered pregnancy and maternity in detail. It detailed the current evidence on this cohort and noted the actions being taken to address low uptake and is provided, [HY4/027 – INQ000502212]. The Clinical Governance Group considered evidence on vaccine safety for those breastfeeding and a Public Health Scotland report from January 2022 provided an update on vaccine safety of those breastfeeding, provided [HY4/028 – INQ000502215]. All of the above work and research was drawn on by the programme to ensure that Health Boards were putting in place supportive communications and delivery models to maximise uptake and counter any misinformation.
91. I do not recall any substantial discussions with UK or Devolved Government Ministers on the issue of countering disinformation. We were certainly all aware of disinformation and took steps, within our own devolved areas of responsibility, to counter it.
92. As I have previously said at Paragraph 423 of my earlier witness statement Module 2A, provided [INQ000233560] "The Scottish Government did not directly refute misinformation with those who were peddling it, but instead worked to ensure our own, factually correct messages were communicated widely". The Scottish Government did

not directly engage with those spreading mis/disinformation – instead they tried to ensure factually correct messages were widely communicated. This required an understanding of common myths and questions being raised in order to form a response. This response was then incorporated into Scottish Government information e.g. proactive comms messaging for dispelling disinformation around pregnant woman.

93. This was in line with international best practice, the FVCV Security workstream chose to not directly engage with anti-vaccination individuals on social media, preferring to point the public to reliable sources of information such as NHS Inform and the Scottish Government website. The same approach was used by Scottish Government Social Media channels. The FVCV workstream did however communicate directly with health boards as well as with directors of education to inform them about antivax and misinformation campaigns targeted at health professionals or education providers, to explain why the contents of these campaigns are false and provide them with reassurance.
94. I recognise that there were some credible voices who urged government to take a far more direct and robust approach to counter disinformation, rebutting directly some of the common, global conspiracies about the vaccine that existed. Government Ministers did often have to engage in rebutting misinformation when it was put to them during interviews, parliamentary debates or in correspondence with members of the public. However, I think it would fundamentally have been the wrong approach to try and directly engage with some of the key proponents of disinformation and conspiracy theories online. The real danger in doing so would have been to amplify the inaccurate information from the fringes into the mainstream. Those of us in senior Ministerial position usually had far more followers, and a greater reach than those who were engaging in deliberately spreading misinformation, engaging directly with them would only give oxygen to those who craved it.
95. Some practical tasks for countering harmful health disinformation led by the Scottish FVCV Security group itself are outlined below:
 - Producing online training for Vaccination Centre staff on staff safety and conflict de-escalation and social media safety for vaccine centre staff.
 - Publicising ongoing security reminders in the weekly FVCV Operational Bulletin for NHS staff awareness.

- Organising a webinar for FVCV Security stakeholders such as NHS and Local Authority staff on Fake News and Disinformation awareness

Vaccine Safety

96. Vaccine efficacy had been part of the information contained in Cabinet paper in November 2020 before my time in post and is provided, [HY4/029 - INQ000078582]. Then on 7 May 2021, again before my time in post, the JCVI published an announcement, provided [HY4/030 - INQ000390090], following findings by MHRA that the AstraZeneca vaccine was associated with extremely rare cases of thrombosis / thrombocytopenia, and recommended that the vaccine not be used in those under 40. Generally, risks came to our attention via the UK wide Yellow Card system which was in place and ensured any risks or side effects were appropriately recorded in this system). Also, the CMO would inform me of any risks associated with the vaccines as and when they were known, provided, [HY4/031 – **INQ000502214**].
97. The knowledge of vaccine risks of course fed into my decision making on Covid-19 vaccines. Generally, information or updates on any risks associated with the UK Covid-19 vaccines were provided through the UK Government formal governance structures and via the JCVI. The Green Book chapter 14a also includes a section on “safety” for each of the vaccines in use at any given time. Daily briefings to the First Minister were used to provide information to the public on a range of topics, including risks, for example, when alternative vaccines were to be offered to under 40 in place of the Astra Zeneca vaccine.
98. Covid-19 vaccine manufacturer patient information leaflets (PILs) were provided to patients at the point of vaccination and are also available on the NHS Inform website. These leaflets provided patient information on possible side effects. The informed consent materials that were sent with the vaccination appointment also contained information on side effects and pointed people to NHS Inform for the PILs and to the MHRA Yellow Card scheme.
99. When making decisions I would take the advice of clinicians, CMO, clinical bodies (JVC). This advice fed into decision-making and was incorporated into public messaging where there were risks e.g. low levels of myocarditis and pericarditis in children and young people. This advice was also disseminated to vaccinators and front facing communicators.

100. I viewed the safeguards which exist to ensure both the independence and impartiality of MHRA and its advisers as adequate. I consider the independence and impartiality of MHRA is crucial. I think interrogation and questioning of it and its advisers to understand decision making is appropriate but that cannot cross the line onto political interference. I certainly did not get any sense there was any undue political influence being exerted on the MHRA, however it is a UK-wide body and the Scottish Government's interactions with it would be very limited. The only improvements I could suggest would be that there is more transparency around MHRA decision-making, and this will improve safeguards and combat disinformation.
101. The Scottish Government did not specifically evaluate levels of public confidence and trust in the MHRA as the UK regulator. There are proxy measures, such as vaccine uptake and adverse event reporting, which may indicate levels of confidence in the MHRA but equally these may be attributable to the vaccination programme itself. I personally do not believe there was a very wide public appreciation of the MHRA or an understanding of what the role of the MHRA was. As Health Secretary I received very little, in the way of correspondence, in relation to the public's concerns around the MHRA.
102. I had no issues with the efficacy of the MHRA Yellow Card monitoring and reporting system. I cannot recall any communication with decision-makers and advisers regarding the adequacy of the system. Indeed, if any concerns were raised about potential side effects of vaccine by members of public or MSPs I would generally point them to the recording of side effects to provide some level of assurance. I think there was a level of transparency regarding the yellow card system too, as there was regular publication of recorded side effects.

Vaccine certification

103. The vaccination certification passport scheme was initially a matter of discussion at Cabinet and it was agreed to take discussion around final decision making to the Scottish Parliament for debate. Indeed, although the DFM John Swinney led on the scheme, I closed the debate in parliament on the matter. The domestic Covid-19 status certification scheme came into force in Scotland from 1 October 2021 and lasted until 28 February 2022. I had significant involvement in the scheme and had a number of

meetings with DFM and stakeholders on the matter and a key role in its public messaging.

104. We introduced the scheme in Scotland following the example of a number of other countries. It only applied to those over 18. Two evidence papers covering domestic vaccine certification, taking the four harms approach, were published by the C-19 hub in Sept 2021, COVID Vaccine Certification – evidence paper and Nov 2021 Coronavirus (covid -19) vaccine certification; evidence paper update provided [HY4/032 - **INQ000383489** and HY4/033 - INQ000131042]. The initial paper was discussed at a Covid-19 Recovery Committee meeting, chaired by the DFM. Professor Christopher Rye, an independent expert, gave evidence to the committee and said he broadly agreed with it.
105. The scheme was to apply only in a narrow range of settings, including live events above a certain crowd size and premises open after midnight with music, alcohol and dancing. Certification was introduced to enable premises to be open but at reduced transmission risk by reducing (but not eliminating) the risk of infected people being present. Reducing transmission was beneficial in terms of reducing harm 1 and indeed other associated harms. When first launched in Oct 2021, it required proof of vaccination; proof that a person had completed a course of doses of an authorised vaccine, with the final dose having been received at least 2 weeks prior to entering the event /premises.
106. From 21 Oct 2021 the Covid Status Certification app – NHS Scotland Covid Status /NHS inform had a domestic screen added. This allowed people to display a full vaccination status required for international travel on the international screen and either a red cross or green tick in relation to vaccination on the domestic screen. The NHS Scotland Covid Status App was produced by NES ensuring domestic premises had a path to check QR codes, which would show a green tick or certificate not valid. We had to limit the information on the domestic app, so as to meet the Information Commissioner’s requirements of displaying the minimum data i.e. only valid status and not personal data. On 06 December 2021 the scheme was amended to accept a negative test result within the previous 24 hours as an alternative to proof of vaccination. On 09 December the Covid Status App was updated to include recovery status, third dose and boosters. The paper and PDF certificates were updated to include the last 2 doses on 13 December. These changes made it possible for people to use the scheme who were not yet fully vaccinated. It also meant those who had had a vaccine not recognised by MHRA, or

who had difficulty accessing their record, would be able to attend venues covered by the scheme.

107. On 17 Jan 2022 the definition of fully vaccinated in the scheme was amended and the app was updated to reflect this. On 24 Jan 2022 the definition of late-night premises was amended and live events were removed from the scheme. On 28 Feb 2022 the mandatory domestic Covid Status certification scheme was ended. Appropriate Impact assessments had been completed for the introduction of the domestic policy and all significant changes to the policy – Equalities and Human Rights Impact assessments (EQIA), Business Regulatory Impact assessments (BRIA) and Children Rights and Wellbeing Impact assessments (CRWIA). All the assessments were published and accompanied the Regulations on the www.legislation.gov.uk website.
108. The main reason in the scheme was introduced was because there was evidence that the virus was more likely to spread during live events with large crowds and premises opening after midnight with alcohol and where contact, such as people dancing together was taking place. The evidence papers showed that this scheme would help reduce the risk of transmission of the virus. We considered the scheme as another tool in our armoury to help reduce the harmful impact of virus.
109. The evidence papers also provided details on the ethical considerations we had to make. It was important to bear in mind that the vaccine was voluntary not mandatory. Retaining health data for this purpose of course engaged ethical considerations and we did what we could to address ethical concerns raised by the public, elected members and human rights organisations. We adapted the scheme so not fully vaccinated people could still access the venues. As noted above we carried out various impact assessments (EQIS, BRIAS, Children rights etc.) and published them on the Scottish Government website. A digital app and paper copies of vaccine certificates were also available, so they were as widely accessible as possible. Where concerns were raised, including by the Information Commissioners Office, we sought to address them as quickly as possible.
110. Exemptions were in place for the small number of people in Scotland who could not be vaccinated for medical reasons. This was later expanded to include those who could not be vaccinated or tested for medical reasons. All clinical trial participants were issued with a letter from their Principal Investigator which could then be used for proof of their trial status. When testing was introduced clinical trial participants were encouraged to undertake testing, as they may have received a placebo dose.

Vaccine Damage Payment System (VDPS)

111. The VDPS is reserved to UKG. I had no concerns on VDPS nor were any conveyed to me during my time in post. I do not recall any meetings between the Scottish Government and the UK Government on the VDPS.

Therapeutics

112. The UK Government Therapeutics Taskforce and their Antivirals Taskforce, and the body created once they had merged, named the Antivirals and Therapeutics Taskforce (ATTF) were responsible for the identification, trials, and availability (including the procurement if necessary) of new Covid-19 therapeutics during the pandemic. A Therapeutics Clinical Review Panel, supported by the ATTF, provided advice on the definition and revision of eligible cohorts for Covid-19 therapeutics, Ministers, myself included, followed the advice of the clinical experts on the Therapeutics Review Panel. The panel was formed of senior clinicians from all four nations and provided advice to the four nations CMOs. Professor Tom Evans was the Scottish Government representative on this panel.
113. Decisions on establishing the effectiveness of existing medicines for treating Covid-19 were initially undertaken by the MHRA as part of the authorisation process. These decisions were based on clinical trials. The MHRA continually reviewed the emerging body of evidence regarding potential medicines for treatment or prevention of Covid-19. Further information on this can be found in the DG Health and Social Care (CMO-CPO) statement (reference M4CMO01).
114. My role in the development therapeutics and repurposing of existing ones was ensuring Scottish participation in terms of the various trials that were ongoing (providing clinical input from CPO and CMO where appropriate). I was supportive from a Scottish Government perspective of the development of all new therapeutics to treat the virus. Whilst there were no specific innovations in Scotland to speed up the development and approval of new therapeutics to treat Covid -19 that I am aware of, I ensured the Scottish Government worked collaboratively across the UK to support the development and delivery of clinical trials. The Scottish Governments CSO invested, through NHS Research Scotland (NRS), in research infrastructure in health boards in order that the NHS in Scotland could host and participate in clinical research studies and trials. This

infrastructure was utilised to support Covid-19 trials of new therapeutics. I also liaised with UKG on supply issues of therapeutics and ensured that the distribution mechanism was fit for purpose and worked well in Scotland. Health Boards also had a role here, although I had national strategic oversight.

115. My role in terms of procurement and supply was limited because this was done at UK level. The CPO attended three meetings with the MHRA from early December 2021 until late April 2022 to gain an understanding of the authorisation and deployment of several of the new Covid-19 therapeutics. These meetings were organised by the MHRA with the aim of helping to support each UK nation's deployment plans, as well as gaining a better insight into the characteristics of the Covid-19 therapeutics. In the initial stages of access to remdesivir, a European Union (EU) joint procurement agreement (JPA) was negotiated to ensure increased volumes of remdesivir until the end of March 2021, after which the manufacturing company, Gilead, expected to have secured sufficient supplies to meet world-wide demand. We received an agreed allocation of remdesivir as part of the wider UK arrangements with the EU JPA. DHSC officials worked closely with the devolved administrations to consider distribution arrangements for any therapeutics that had been procured on a UK basis, including the allocations to the devolved governments and any associated logistics in terms of distribution and storage.
116. I do think sufficient action was undertaken, both in Scotland and the UK, to develop and make available non-vaccine prophylactics for Covid-19 (including Evusheld) to address the needs of immunosuppressed and immunocompromised people, among whom vaccines are likely to be less effective. Those who were immunosuppressed and immunocompromised were a high priority in Scotland when it came to us ensuring we reduced risks of harm from the virus (this was reflected in the range of interventions that we took early on in the pandemic e.g. shielding). The possible provision and use of Evusheld occasionally was raised with me. There was a vocal lobby group within Scotland (particularly those who were immunosuppressed and immunocompromised) who wanted Evusheld widely available on NHS. I sought advice from the CPO on this matter. Ultimately it was considered that there was not a strong enough evidence base that Evusheld would be effective against the circulating variants at that time (Omicron), and I therefore chose to follow the clinical advice in this regard.

Evaluation and Lessons Learned

117. With regard to any lessons that can be learned to prepare for and/or tackle a future pandemic in relation to matters identified in the Provisional Outline of Scope for Module 4 I would comment as follows:

- Firstly, there is little commentary I can provide on the development of the Covid 19 vaccine as this was before my time as Health Secretary. However, as a member of the Scottish Government at the time, the breakneck speed at which the vaccine was developed was clearly impressive, and I am certain learning from this period has been adequately captured.
- For any future pandemics, one of the key lessons we must learn, and I know work is being done on this, is to create a sustainable vaccinator workforce, that can be deployed at speed. We cannot assume that other primary health care workers will be readily available, so the work on creating a resilient workforce is absolutely vital for future vaccine deployment.
- Notwithstanding the above, discussions with professional bodies representing primary care workers should take place, with plans developed and if possible agreements secured to co-opt the primary care work force as vaccinators should they be required.
- Plans should now be developed by each health board to identify appropriate venues that will allow for as many people to be vaccinated as quickly as possible. In urban areas, these are likely to be large, easily accessible venues, in rural and island Scotland identifying smaller venues but a greater number with good geographic spread will be essential.
- Conversations should be had now, particularly in remote, rural and island areas of Scotland, with GP practices. While GPs in Scotland are no longer administering vaccines due to recent contract changes, there are some GPs, particularly in rural Scotland, who are willing to be part of the programme. An exploration of the efficacy of involving them in any future vaccination programme should be done now, in order to ensure we are best prepared.
- We know the demographics where vaccine uptake was lowest. Proactive efforts should be made, between pandemics, to engage with those communities to

understand what can be done now – not when a future pandemic hits – in order to remove barriers to vaccination.

- In terms of age cohorts, vaccine uptake was lowest amongst young people. Government should be considering what steps can be taken now to work with youth organisations, the third sector, schools and social media influencers in order to inform young people about the benefits to them, and society at large, from getting vaccinated.
- It is important that steps are taken to ensure we keep up with technology, as opposed to playing catch up, as it felt like at times with the vaccination programme during the Covid Pandemic. We came with a digital booking offer late. It would be far better to invest in the latest technological advancements, given we don't know when the next pandemic is likely to hit, so that a booking system is in place at the beginning of any vaccine programme, not mid-way through.

118. The key barriers and challenges that existed have been mentioned in this statement already, before restating some of them, it is important for me to emphasise my view that I believe the vaccination programme was incredibly successful, and all of those involved, particularly the front-line workers should be very proud of their efforts.

- We had challenges with uptake amongst certain demographics. These was a range of reasons for this hesitancy amongst certain groups, as already stated in this personal statement. Some of those challenges were due to the spread of disinformation, others due to the lack of information from trusted community sources, and other reasons were vaccine fatigue. My particular concern with the prolific spread of disinformation on social media is that it has become even worse since the pandemic and I worry that we do not have an effective means to counter this disinformation, especially in the face of bad-faith actors.
- The other key challenge was workforce. At times, such as during the boosted by the bells campaign, we had to achieve a particularly high vaccine run rate in order to ensure we had the overwhelming percentage of the population vaccinated ahead of times where human contact and interactions were to increase – such as during Christmas and New Year. Redeploying staff had consequences for other care that could be provided by the NHS. The use of those who had retired from the NHS and

were asked to come back to help with the vaccine effort worked well. Formalizing and digitizing the register of retired nurses, and other NHS staff (such as primary care workers) would be helpful to assist with future pandemics.

- Other key challenges included ensuring we had enough and appropriate vaccination centres, this became particularly acute when restrictions eased. We cannot assume there will necessarily be the same level of restrictions at the time of any future pandemic, so identifying adequate venues for vaccination centres now with this in mind, as part of the pandemic preparations would be helpful.
- Geographical variances were evident during the programme, and while uptake of the vaccination programme in the Scottish Islands was largely in keeping, often better, than the mainland, there was times when areas of remote and rural Scotland struggled due to accessibility issues. I know that health boards covering Scotland's rural areas are already exploring how those challenges can be overcome for future pandemics.
- I was a proponent of the Covid-19 Certification Scheme, in fact I think we should have sought to introduce it sooner to allow restrictions to possibly ease sooner in some venues. There were some key barriers at the time of introduction including our digital capability and issues around information collation and retention, as referenced by the Information Commissioner at the time.

119. The disparities in vaccine uptake necessitated work to both ensure inclusion was embedded throughout the vaccine programme, and to make concerted outreach where necessary. The aim of this inclusive approach was to remove any barriers to vaccination and to ensure no community was left behind. The Scottish Government set up a Vaccine Equalities and Inclusion team to undertake this remit. I think it is imperative that we incorporate the recommendations of the Expert Reference Group on Covid -19 and Ethnicity and ensure that all the issues they raised should be considered and if appropriate be incorporated for uptake of vaccines in future pandemics. For instance – making ethnicity a mandatory field for health databases; coordinated action; more participation in minority ethnic communities; monitoring of workforce data.

120. Further things that I think we can continue doing or develop are:

- Local health board plans – they have already identified mobile assets that can go out to various places of worship/community centres/areas of higher deprivation/homeless shelters (these should be implemented and utilized immediately without waiting for feedback on necessity).
 - Continuing discussions with a variety of representative organisation to allow a template for public messaging to be established (in various languages, using trusted voices).
 - We should start using trusted networks to begin to have those conversations.
121. We introduced a question on ethnicity to the Vaccine Management Tool (VMT) on 18 November 2021 which meant that people attending a Covid-19 and flu vaccination appointment were asked their ethnicity for the first time when receiving a vaccine. The question was then added onto the online booking portal and National Vaccine Helpline from 23 December 2021. By the winter 2022-23 programme, ethnicity was assigned to 93% and 90% of Covid-19 and Flu vaccine records respectively. Other vaccines have since been added to the VMT (shingles, pneumococcal), therefore, the ethnicity question is now asked at these appointments too, if this field has not already been entered for the patient. We should continue using this for all vaccines.
122. Regional and geographic inequalities – large, dispersed geographies (e.g. the Highlands) Health Boards should have a plan to ensure there is adequate vaccination centers/hubs there and that they have a more flexible approach to the use of willing GPs.
123. I am not sure as to whether any lessons can be drawn from differing approaches taken in the four nations of the UK in respect of the topics covered in the Module 4 Provisional Outline of Scope, largely down to the fact that there were only marginal differences in the vaccine programmes across the UK, and uptake figures were broadly in alignment across the nations, with NI at times being an outlier. Any differing approaches amongst the four nations, and a degree of flexibility was necessary due to differences in geography (e.g. accessibility of island communities in Scotland). I think the continual engagement at official-to-official level will remain important for future working. I would also add that small tweaks to a uniform approach often made a difference e.g. allowing flu and covid vaccination to be taken at same time in Scotland made a difference to uptake of both vaccines.

124. It should be restated that I am no longer in the Scottish Government, therefore my understanding of the current state of contingency planning is limited. However, I understand Scottish officials are currently working with four nations colleagues on a number of UK-wide projects and plans related to pandemic preparedness which include vaccine deployment. Work is also underway in Scotland with Public Health Scotland and other partners to consider our preparedness plans for various pandemic situations, including regards to vaccine deployment.
125. My strong view is that there should be oversight of contingency planning by a panel of experts that are independent of Government. Clearly, the work of this Inquiry, including its findings, and those of the Scottish Covid Inquiry will be incredibly useful for identifying the lessons that need learned, and requisite action and future planning required.
126. I consider that the correct balance was struck between investment in and development of vaccines and investment in and development of therapeutics. It was important that investment and development of both took place in parallel twin tracks. Early in the pandemic, the UK Government established two governance structures - the UK Vaccines Taskforce and the UK Vaccination Delivery Programme. Vaccine research along with funding, manufacturing and procurement was led by the UK Government. Scottish Government officials, and therefore Ministers, were kept up to date on this via the four nations Programme governance, which also provided an opportunity to feed in any specific requirements from the Scottish Government.
127. Both strands of work were important and took place in parallel. NERVTAG advised the CMOs and the DHSC, and carried out an assessment of thousands of potentially viable existing pharmaceuticals that could be repurposed. They recommended prioritisation of potential therapeutics for formal evaluation in clinical trials. Meanwhile the Antivirals and Therapeutics Taskforce and its predecessor bodies was responsible for identification, trials and availability of new Covid -19 therapeutics.
128. Scotland participated where appropriate with therapeutics trials, but ultimately it was the responsibility of the UKG. I think really it would be for clinicians to advise whether there should have been greater clinical impacts in the development of therapeutics. However, I believe that if there had been, it would have meant effort and finances being taken away from vaccines and I am not convinced that this would have been the correct balance. The vaccine was our most effective tool in combatting the virus and this was backed up by a number of clinical studies.

129. I think there was innovation in several aspects of the delivery of the Covid-19 vaccine deployment programme. There was innovation around public messaging, use of social media and social media influencers; the scale and diversity of demographics reached with trusted voices. Also, the numbers of workforce deployed to deliver vaccine - the Regulations were amended to allow other people to deliver vaccine (opticians, dentists, other health care professionals). Our vaccine management tool was innovative - it digitised the booking platform and improved ease and accessibility to vaccines, as was the certification scheme. The deployment of mobile assets was also innovative - vaccination buses, ambulances and units being sent to football grounds, places of worship and homeless shelters.

130. I don't think there were any significant drawbacks to any innovative approaches detailed above. However, perhaps, it should be noted that regarding workforce, this initially at least, involved deploying significant numbers of primary care workers unable to do their day job due to IPC restrictions. This was only temporary until they could return to their core roles. Going forward I think it is important to have a sustainable plan in place regarding the workforce required to deliver any vaccine. Also, with regard to the mobile units, this required a significant degree of staff resource and money, and accordingly may not always be as practicable as desired. However, having said that, I do think all of the innovations mentioned in paragraph 129 above should be made permanent. The ethnicity data collected during vaccinations should also be made a permanent feature.

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.

Signed:

PD

Dated: 23 October 2024