HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Take-up of the Covid-19 vaccines in BAME communities and women, HC 1224

Wednesday 10 March 2021

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Watch the meeting

Members present: Caroline Nokes (Chair); Ben Bradley; Theo Clarke; Elliot Colburn; Angela Crawley; Alex Davies-Jones; Kim Johnson; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 36 - 80

Witnesses

I: Kemi Badenoch MP, Minister for Equalities, Government Equalities Office; Nadhim Zahawi MP, Minister for Vaccine Deployment, Department of Health and Social Care; Antonia Williams OBE, Director of Covid Vaccine Deployment, Department of Health and Social Care.

Examination of witnesses

Witnesses: Kemi Badenoch, Nadhim Zahawi and Antonia Williams.

Q36 **Chair:** Good afternoon and welcome to this afternoon's evidence session on the take-up of Covid-19 vaccines in BAME communities and women. We have as our witnesses this afternoon Nadhim Zahawi, Kemi Badenoch and, from the DHSC, Antonia Williams. Thank you all very much for joining us this afternoon. It is very much appreciated.

You will be aware that we held an evidence session last week where we heard from a range of witnesses, all of whom made the point that the low vaccine uptake and the vaccine hesitancy from some communities was predictable. Was that your view and, if that is the case, at what point did you start planning for there to be a programme to encourage vaccine uptake?

Nadhim Zahawi: When we began the process, even before my time, NHS England was already designing the deployment infrastructure, if I can describe it as such to the Committee. If you recall, we started deploying on 8 December with a rather challenging vaccine; I will come back to that, because that is equally important to this question. The Pfizer-BioNTech vaccine needs to travel at -70° C, so we began deploying at hospital hubs and then primary care networks—a few hundred that week—and did the same for AstraZeneca on 4 January, because you have to get the safety protocols right. Chris Whitty, the chief medical officer, quite rightly insists we spend at least 24 to 48 hours making sure we monitor the deployment in hospital hubs and then we roll out to primary care networks.

The NHS, in designing the standing up of various vaccination sites in terms of primary care—this is the PCNs, as we refer to them, so five or six GPs coming together and deciding who would lead, with the others supporting—looked very much at deprivation as part and parcel of the design. More sites were stood up, especially when we got to the AstraZeneca-Oxford vaccine, which was much easier to handle. Clearly, with the Pfizer vaccine, there were some challenges that made some PCNs want to wait and see in phases, which had an impact. For example, in London, if you look at the schedule of standing up different parts of the infrastructure, it was much more even. In the north-east they frontloaded, so more PCNs came earlier on. NHS England, from the outset, was looking at uptake, and, within uptake, size of household, deprivation and so on, in designing the infrastructure.

Kemi Badenoch: How much did we know in terms of seeing the hesitancy in uptake? A lot of it was anecdotal. One of the helpful things about having ethnic minorities in these ministerial positions is that we have a totally different perspective, or rather an additional perspective, and you get early warning signals.

You will remember that back in 2020 we did not even know if we were going to have a vaccine, and the emphasis was on trials. We could see the misinformation around the vaccine being tested on ethnic minorities and things like that. That was one of the reasons why, very early on, I decided to go on vaccine trials and encouraged others to do so. Nadhim did the same thing. All of that was trying to build the confidence in people that this is something that is safe and that we want to encourage as many people as possible to get involved in, and to improve their understanding of what trials mean. All of that thinking rolled in once we had vaccines ready, once we knew that we had something that was regulated and ready to go, continuing to use those methods of ensuring that people understand exactly what it is, who is going to be taking it, why they should be taking it and a lot of things around our general communication.

On vaccine hesitancy, we were certainly alive to it and looking at it even before the vaccines were prepared. We can see the impact of that in terms of the changes in terms of people's perceptions of it so far.

Q37 **Chair:** One of the witnesses last week made the specific point that the communications around the vaccine were not around how safe it was or around the technical information. He felt that it was just the message of, "Take the vaccine". Do you think that more could have been done to better articulate to people the safety of the vaccine and the importance of the vaccine, rather than simply encouraging people to take it?

Kemi Badenoch: I do not recognise that. That is something that we definitely did. If you go to the NHS website, there is a lot of explanation around the safety of it and how it works, because much of the disinformation related to, for those people who were somewhat knowledgeable, why it was based on mRNA and lots of weird and wonderful conspiracy theories related to Bill Gates. We did have messaging around the safety of it. Getting people to take it was all part of that; they were not disconnected. I am not sure why he felt so. The safety of the vaccine was something we promoted as much as possible and it was also messaging that we gave to GPs. At the end of the day, it is not Ministers who are talking to people about the vaccines; it is local health workers. That was something that was part of the communication strategy and the stakeholder materials that we gave to them.

Nadhim Zahawi: Everything that Kemi highlighted is absolutely right. If you recall, when the MHRA approved the Pfizer-BioNTech vaccine, we had them hold a press conference, with June Raine and the clinical experts from the Joint Committee on Vaccination and Immunisation, and essentially take the country through the process of the regulatory approvals but also talk about the clinical safety and the rigour around that. We then repeated it again for the AstraZeneca vaccine in the new year. It was the same thing, with the clinicians, the regulator and the four chief medical officers leading the communication strategy.

We have done the same with Moderna. It has not yet come online to be deployed, but the MHRA looked at Moderna. We will do the same with each vaccine as we get through that. That is a big moment, especially for the Pfizer-BioNTech, because we were the first country in the world to give regulatory approval to the first vaccine against Covid.

We continue to do the same thing. If you look at our comms strategy, which is based on a national, regional and then hyper-local strategy, we continue to always go back to the clinical advice, whether it be from, as Kemi mentioned, your doctor or your GP, or an individual going on and saying, "I have been vaccinated", because the frontline healthcare workers were in group 2 of the top nine cohorts of phase 1. That has been incredibly effective, with practitioners from different communities coming out and saying, "I have had my first dose. Talk to me about what questions you might have".

We also, by the way, held a number of sessions with the practitioners themselves, because some of them had questions as well. We had the JCVI, CMO and deputy CMO take them through all of the questions that they had that were around the trials, the regulatory approval and any other questions, which I am sure we will touch on in this Committee as well.

Q38 **Chair:** We also heard that there had been a lack of involvement from women in the communications. While young women are not yet a priority group, it will come to them; we will be rolling it out down the age bands. What preparatory work is being done to make sure that there are not concerns from young women about taking this vaccine? How are you including female voices in those comms?

Nadhim Zahawi: That is really important. Many of you will now be familiar with Dr Nikki Kanani, who is the director of primary care in the NHS, because she has done a number of press conferences both with the Secretary of State for Health and with the Prime Minister. It is not just Nikki; there is the brilliant Dr Farzana, who took it upon herself to ring each and every one of her patients to talk to them about any vaccine hesitancy in her GP practice and their primary care network. Of course, as I said on International Women's Day—I do not know if any of you follow me on Twitter—without June Raine, who is the regulator, and Emily Lawson, who is our senior responsible officer for the deployment campaign, and Kate Bingham, of course, and the brilliant scientists who led for both Oxford and BioNTech, we would not have a vaccination programme.

We want to keep making sure that we communicate to women, because some of the anti-vax messages, which are clearly directed at both young men and women around fertility, are false but proving to be sadly quite potent. Some of the focus groups and polling evidence suggests much of the hesitancy is around issues around fertility.

Q39 **Chair:** How do you feel that the Government's equalities agenda has

been embedded into the vaccine rollout programme?

Nadhim Zahawi: From day one, it has been integrated. I will tell you for why. There are a couple of things. First, it has always been a priority at NHS England. We now have an equalities board. Also, it is a standing item in our ops meetings. At the daily ops that are chaired by Emily Lawson, there is a standing item around the challenges that we face in reaching every group in society. Equality is very much placed into that, including health inequalities. That is really important.

Some of the thinking and the design around this was done very early on, and it continues to deliver. The uptake strategy I launched on 13 February was very much the work of NHS England, supported by the Department of Health and Social Care. Antonia Williams, who is with us today, can speak more about that. That whole strategy is now being implemented. Of course, we all want things to move really fast and deliver. The strategy is working and we have to keep focused on that.

Caroline, you and I entered Parliament together, and sometimes in Government we do a lot of thinking and a lot of policy work; when it comes to implementation we try a little bit and then we run out of steam, we run out breath or something happens politically, and then somebody says, "No. Let us try something different". My very strong sense is that I urge everybody, whether I am around on the project or otherwise, to stay focused, because the strategy is working. Just keep delivering.

I have seen it in Brent Mosque, in Jesus Centre and pop-ups coming up everywhere. When you talk to the people being vaccinated, it is that place that is convenient to them and that they trust. That is beginning to bear fruit, and that is absolutely at the heart of the strategy. We could talk more about the strategy, of course, and the work with local partners.

Q40 **Chair:** You used the word "now": that you now have an equalities board in NHS England. When was that set up?

Nadhim Zahawi: For this particular programme, I think the board has just been constituted, but there has been a standing item from day one of the design of the deployment programme. As I said to you, for example, in the design of the primary care networks' deployment, the whole health inequalities and deprivation indices were part and parcel of designing the implementation of the primary care networks standing up vaccination sites.

Chair: Perhaps Antonia can answer.

Antonia Williams: So the vaccination equalities committee was formally constituted at the beginning of the year, building and bringing together a lot of work that had been done over the past year, right through from the beginnings of vaccines being on the agenda as a possible scenario; clearly no one knew if one might end up being successful. That was in terms of the planning, but the committee was constituted at the beginning of the year.

Q41 **Chair:** What is the beginning of the year? Some would argue that we are still in it.

Antonia Williams: January—very early in the beginning.

Q42 **Theo Clarke:** Minister Zahawi, what data are the Government currently gathering on vaccination rates and refusal rates? Could you explain why you are collecting this data and how it will be used?

Nadhim Zahawi: We have three sources of point-of-care data: the Pinnacle, NIMS and NIVS systems. Essentially, for each vaccination event, ultimately the database that holds all of that is the National Immunisation and Vaccination System, NIVS. We then feed all that into our analytics tool, which is the Foundry tool that sits with NHS England and Public Health England. We look at that as part of our daily management tool in the deployment programme.

We also collect ethnicity data and publish that now. We share data as granular as 4,000-household size with local government, because the uptake strategy is very much about integrating the work of NHS England with local government and the local government champions programme, which we can talk about later on. We do all of that together.

We do not centrally hold data on refusal rates, but we know the size of each cohort, or we can certainly use different datasets to estimate, whether it is ONS data or otherwise. We know how far we are getting in terms of vaccinating each cohort. We continue to publish that, and we publish by age now. As we go down each category—we are on category 8 now of the vaccination of phase 1—we will continue to publish that data and share it with colleagues at a constituency level as well, because MPs have a really important role to play in this, as do councillors and local government. We are putting together things like a toolkit for colleagues to use.

Delivering a message of vaccine positivity has worked really well for us. When I took this job on, back in mid-November, if you look at the ONS data and other published polls, vaccine positivity was in the high 70s, touching 80%. Now 94% of the UK adult population are saying that they are likely or very likely to take the vaccine. For your Committee, watching that number continue to climb is the best measure that the strategy is working. It is the highest in the world, if I am not mistaken, in terms of vaccine positivity.

Of course, whether it is 6% or 10% of those who are hesitant, it skews heavily towards black, Afro-Caribbean Bangladeshi and other communities. That is what we are trying to address as well.

Q43 **Ben Bradley:** On that point, Nadhim, you talked about different and very specific communities, and race and ethnicity within the data. One of the things that came up within the evidence last week from all the witnesses was this challenge of talking about "BAME" as an umbrella term, but it is a very diverse group of people, with different views and faiths, within it.

Have the Government considered collecting data about things like faith, for example, and how that impacts on vaccine hesitancy? Is it something you would consider? If not, how do you go about getting down into the real gritty details of those individual viewpoints within that big "BAME" umbrella?

Nadhim Zahawi: That is a great question. One of the things that the uptake strategy does is to talk about that partnership with local government. Local government is incredibly important to the uptake strategy. Within that, we have launched the community champions scheme; that has recruited now over 1,000 community champions, with more than 400 about to come online as well. We also, of course, focus on faith groups and of none.

Your question is incredibly important. To use a polling word, we segment and try to focus on each and every group to make sure that we are engaging with that community and then resourcing them. This was one of the pieces of evidence we discovered very early on about the issue around vaccine hesitancy. Especially if you are in social care, for example, in residential elderly homes where you are looking after those most vulnerable, who are category 1 in phase 1 of the vaccination programme, or if you are from, say, the Bangladeshi Muslim community in the East London Mosque or Brent Mosque, or in Jesus Centre if you are black Afro-Caribbean of Christian faith, you want to go to a place that you trust and at a time that is practical for you in your day.

If you are working shifts, it is much harder if the GP has been to your care home and you happen to not have been on that shift. What we have done over the last 10 days is actually begun the process of going back into the care homes. The plan is to return four times to do the two doses. You go the first time and then have to return a second time, if any of the residents were infected, to give them the first dose after 28 days. You also do the staff at the same time. We have begun to go back again with them now. When, for example, we opened up the national booking system to social care, in one week we saw over 120,000 bookings come through the line, because it was much more convenient for people to book in that way and get their appointments.

We are also then making sure that we talk to places that want to host a pop-up, whether it be a church, a mosque or a temple, and we have amended the GPs' contracts to allow for them to do that. All of that is really working well, and you will begin to see that reflected in the uptick in the numbers of each of those cohorts that we are focusing on.

Q44 **Ben Bradley:** The trust element really came across in the evidence last week, in terms of people wanting to hear from others in their community, effectively, about it. I welcome what you have said there. Kemi, is there anything you wanted to add on that BAME or the more granular data, if that comes into your remit?

Kemi Badenoch: In terms of the approach we are now taking in the Equality Hub, if you read the letter that the chair of the Commission on Race and Ethnic Disparities wrote to me at the end last year, it was one of his recommendations. It is a cross-party belief that using those acronyms to describe what is actually an unbelievably diverse group of people does not help to get to the nub of the issue.

Where possible, we look at things specifically around groups. In a lot of the data I have been putting out in my disparity report, we separate out Pakistanis and Bangladeshis, because what is happening with them is different to what is happening with black Africans, which is different to what is happening with black Caribbeans. Lumping everyone together in a group as a proxy for "not white" is not how we deal with things from a health perspective.

Doing that also means that we end up forgetting about lots of other white groups. If you are just using skin colour as a proxy for minorities, that is not accurate. White groups such as the Gypsy, Roma and Traveller communities, and lots of new and sometimes temporary seasonal eastern European communities—people who are not necessarily here throughout the year—all end up being left out. Orthodox Jews are another group. They all end up being left out under the BAME category. I say this repeatedly because it is a very important point to make: ethnicity, in all the research that we have had summarised to us, is not the risk factor; it correlates with a lot of things. We cannot use skin colour as a substitute for directing policy.

Q45 **Ben Bradley:** I totally agree. Moving on from what you have just said there, Kemi, the Chair asked earlier on about the Government's equality agenda. You mentioned the Equality Hub and looking at some of those different elements beyond the Equality Act itself. In terms of some of the other factors, I represent one of the most disadvantaged communities in the country, and I am very aware that there is this vaccine hesitancy within the most socioeconomically disadvantaged communities as well. I have the figure here that 60% of adults have that hesitancy in those communities compared to 7% in the more affluent communities. When you look at the rollout and at these factors, do you look beyond the Equality Act and those things? Do you look at that socioeconomic disadvantage?

Kemi Badenoch: Yes, we do. Deprivation is one of the things that we take into account. You are right. If you remember what the Secretary of State said in equalities orals and in her speech at the end of last year, we are looking broadly, not just at protected characteristics. That is partly because often people assume that "protected characteristics" means some specific groups, which is not what the Equality Act actually says. The Equality Act is really around anti-discrimination, but there are lots of disparities that are not related to discrimination, which often get left out of the picture. We want to bring all of that back in.

We look at things from a regional perspective. Our data has shown us that different regions were impacted in different ways during the lockdown. Areas in the north, particularly, that had very high levels of south Asian communities were impacted in a different way from what we saw in the first lockdown. We know that just looking at things within the boundaries of the Equality Act and protected characteristics will not be enough; there will be so many people who fall through the gaps.

It is probably helpful to talk about what exactly the agenda is from the Equality Hub. I think that was a question that Nadhim had asked earlier: what is the strategy? Being data-based is absolutely critical. We separate what the data actually says and tackle that differently from how people feel and what comes out in qualitative surveys, which often need a different approach.

That second approach often relies on us not stigmatising groups. With many of the recommendations that I hear or that you see on social media, what people are actually talking about is segregated race policy in health, which is something I am completely against. I do not want to see the stigmatising of particular groups, whether they are white or black, working class or any specific religion. Sometimes an over-focus on a specific group will stigmatise them. That is bad for trust at a time when we need people to have trust in authority, Government, health authorities, their local primary care networks and their local government officials. We need people to be able to trust these bodies. It is often unhelpful to overly focus on particular groups. That is how our strategy should be playing out in terms of each individual policy in this space.

Nadhim Zahawi: As I talked about earlier, even in the design of the deployment infrastructure, deprivation was very much part of that design of standing up vaccination sites. Obviously, there were some limitations around the first vaccine, which was much tougher to handle because of the cold-chain transport, but that was very much part of our design process.

Q46 **Kim Johnson:** Good afternoon, panel. Nadhim, I just wanted to find out what happens to those people who are not registered with a GP. You mentioned earlier that people are contacted by GPs and PCNs. What happens to those with no recourse to public funds and homeless people, who tend to be quite transient and who may be at higher risk of contracting the virus?

Nadhim Zahawi: You are absolutely right. I spoke to people who are undocumented migrants, which goes to your point around no recourse to public funds, to say that people can come forward because we want to vaccinate every community. You saw some really good messaging from the Home Office around this: that if they come forward they will be safe. They can get their vaccine; they do not even need an NHS number to get their vaccine, and they can do it either by booking a vaccination, if they are in the eligible cohort, or through a GP. If they do not have a GP, we have also amended the GP contracts to allow for them to take people on,

to be able to give them the vaccine if they are not registered with them already.

A lot of work has taken place on this, including, of course, making sure that we communicate this out to those communities. Group 6 in phase 1, which is a very large group of about 6 million people, includes those who are homeless. There is some excellent work being done. There was a brilliant tweet the other day from the director of public health at Newham Council saying that not only have they set up pop-ups in a church, a mosque and a temple, but also in a homeless shelter, because they are eligible to be vaccinated under cohort 6. The JCVI is also putting something out on this imminently.

Kim Johnson: Thanks for the update, Nadhim.

Q47 **Theo Clarke:** I have a question first to Kemi but then to all of you. Professor Nicola Stonehouse has urged the Government to gather data by sex and age for the vaccine update, so that it is easier to spot vaccine hesitancy in young women. I just wonder if that is something that the Government have considered.

Kemi Badenoch: Data by sex is collected by NHS England in the vaccine programme. It is not currently published, but how the data informs the uptake and the equalities work of the programme is constantly under review. We publish UK-wide data on the total number of vaccines and obviously the cohorts have been age-based, so this is something that is known.

The focus on young women at the moment is not something I am particularly worried about. The ONS figures say that 34% of men who are eligible say they have had the vaccine; 44% of women who are eligible say that they have had the vaccine. The hesitancy rates that we have seen are pretty much the same across men and women, so, whether or not we have that data and publish it, I do not think it is going to have a meaningful impact on vaccine uptake, beyond a lot of the programmes we are doing already.

Nadhim Zahawi: That is right. Kemi has pretty much covered the points. You combine the data you are able to gather at the point of care. We are at 22.6 million vaccinations of first dose; it has been a really positive experience for people. You want to be able to almost gauge how much data you want to collect at point of care versus how some of your research data can give you similar information, which is what Kemi has just quoted to your Committee, that is actionable. We know that among the younger cohort there is that hesitancy. You then begin to want to dig deeper and understand where it is coming from. Is it around vaccine safety? For the younger cohorts, is it around, "I am not very likely to be harmed by this virus anyway, so why should I take the vaccine in the first place?" Is it around links to safety and the disinformation and misinformation around fertility? That is all actionable data. You do not

have to collect every piece of data at point of care and make the process so onerous on someone coming to have their jab.

Antonia Williams: I would just add to what has already been said that we are very committed to transparency across the programme and increasing the amount of published data all the time. Clearly, it has to be properly verified so that we have confidence in the numbers. On a weekly basis, NHS England is putting out a significant amount of data, and giving local authorities and directors of public health every day a significant amount of actionable data to help them understand and target in local areas. It is a big priority for the programme across the board.

Q48 **Kate Osborne:** My first question is to Minister Badenoch, please. Earlier, Minister Zahawi touched on engagement across communities via faith groups and community champions. Can you tell us what steps the Government are taking to ensure that communications surrounding the vaccine are linguistically and culturally appropriate?

Kemi Badenoch: There is a lot of work we are doing in that space. It is almost too much for me to even begin to recount. It is a fundamental part of the Government's response. We are ensuring that the messages are accessible and published in a large number of publications that ethnic minorities read, watch and listen to. DHSC has done regular interviews for clinicians in particular, because it cannot be just Government Ministers doing these things. We have set up meetings and interviews for clinicians with more than 20 ethnic minority newspapers and programmes, such as the *Voice*, BBC Asian Network, Al Jazeera, British Muslim TV, the *Jewish Chronicle* and *Hamodia*. We go to a lot of the outlets that target those groups.

We have done a lot of translation work. Our comms have been translated into about 13 languages, including Bengali, Punjabi, Gujarati and Chinese. For the print and online material for national, regional, local and specialist titles, they all have access to the translation services. We have done some stuff that has to be for radio, because it is not just about languages and communications; literacy is an issue, so making sure that people have access to the messages on broadcast is absolutely critical.

Focusing on those who do not have English as a first language is not just something that we do via the comms policy. Even with the vaccination sites and vaccination centres, we make sure the support is available at sites for those who need assistance, through access and navigating the process. All the sites have access to the guidance, which is updated and published regularly, on what to do in those scenarios where information on translating and making communications accessible is needed.

Q49 **Kate Osborne:** Nadhim, can you tell us how the Government are identifying and addressing the barriers to vaccine uptake? As an example, women may be unable to go to an appointment if they could not take their child or children with them. Can you tell us what steps you are taking to address these kinds of barriers, please?

Chair: Can Antonia take that question in Nadhim's absence, please?

Antonia Williams: I am happy to. The first thing I would say is that designing the overall infrastructure and the location of vaccinations sites has been planned to make them as accessible as possible. By the end of January, 98% of people lived within 10 miles of a vaccination site; otherwise, a team would go to that individual. We have tried to build in maximum flexibility and different channels, so people could be invited to go to a vaccination centre or by their GP, and can make the choice about what would be most convenient to them. The national booking system gives a range of appointment slots. For an individual who is a mother or father trying to juggle with childcare, they would be able to have flexibility about where and when they go. We have also tried to make the process as streamlined and as fast as possible, so you can be in and out.

Clearly, there is a balance. The sites have to be Covid-secure and all follow infection prevention guidance, and therefore locally, although I am sure individuals will have babies in arms, children are not encouraged to come the vaccination centre. I hope that the flexibility and access is there to give people the scope to be able to make that work.

Nadhim, I was just answering a question about how we are supporting parents with childcare in trying to get vaccinated.

Nadhim Zahawi: My apologies, Chair; the system just threw me off completely.

Q50 **Kate Osborne:** I will repeat the question. It was about how the Government are identifying and addressing barriers to vaccine uptake? Parents, particularly women, are having to take their child or children with them, which could be a barrier. It is really about identifying any barriers in terms of vaccine uptake. I do not know if you had anything to add there, Minister.

Nadhim Zahawi: Antonia has covered the points around choice and support that is available, but there are all sorts of great initiatives, some of which are working with charities. In Hammersmith and Fulham, Age UK is offering free transport to people, to get the over-60s to the vaccination sites.

I was visiting a mosque. As part of the pop-up programme, we have put £4.2 million through CCGs, on top of the £23 million on community champions and amending the GP contracts to allow them to do pop-ups. The mosque was working on a pop-up after Iftar, because we are about to enter the month of Ramadan. Again, going back to the issue of convenience, access and support, it is a place that the community trusts; it is a place where they have made provision for women and men. I saw it first hand. They were also thinking, "If people are coming for Iftar in the mosque, what a great way to then also book them in afterwards to have their jab."

Q51 **Kate Osborne:** In my constituency, up in Jarrow in the north-east, one of our local taxi firms was offering free taxi rides, even waiting the 20 minutes or so to then take people back home, particularly in the initial rollout for the most elderly and vulnerable. There are some really fantastic community champions out there doing great things.

My final question, again, is for Minister Zahawi: what advice are the Government giving to employers regarding their employees attending appointments?

Nadhim Zahawi: There is some really good work being done with employers, and many employers are coming forward. I was speaking to a group the other day who are communicating with their employees. As we begin to go down the age cohorts, this becomes even more important, as you get below retirement age, certainly. They are giving them the ability to go and have their vaccine during worktime. We have been getting employers to champion that, because it is also in their interest that their employees are vaccinated. Of course, those in the care sector, such as Barchester Healthcare and others, have themselves been doing some really great work with their employees to make sure that they can access a vaccine as easily as possible.

Q52 **Kate Osborne:** You have kind of covered it, but my supplementary to that is about what you are doing to ensure that employees are not penalised for taking off the time that they might need to attend appointments. As you say, it may be that this cohort of people are only just coming through now, but are you aware if there are many employees having issues? What would you, as a Government, be doing to make sure that does not happen?

Nadhim Zahawi: Up until now, we have seen incredibly positive behaviour. It has been quite the opposite, i.e. employers saying to their employees, "Get the vaccine. If you need to have an appointment during worktime, we want you to go out and get vaccinated." I am the Business and Industry Minister, although I have handed over my responsibilities while I focus on the vaccine deployment; it is in the interest of all businesses, large and small, to get their employees vaccinated.

There was a good example that we announced a few weeks ago and launched last week, which was not on vaccination but on testing. If you are an employer now of 50 employees, you can have test kits for free to test your staff in the way that NHS has been doing frontline for weeks and months, as are social care and schools now as well. The uptake has been really positive among employers. In many ways, we are pushing against an open door here on this, because the sooner we vaccinate the nation, the sooner the economy returns to its dynamic self.

Q53 **Nicola Richards:** The evidence we have heard in the inquiry so far suggested a limited awareness of the Government's community champions initiative. How successful has it been at increasing vaccine take-up in hesitant groups?

Nadhim Zahawi: We have 1,161 community champions in place across the participating local authorities. I said earlier that there were a further 400 earlier; there are 774 reported as being recruited already in this past one-month period, of which 418 are already active. That is where I got my 400 number.

Some 97% of the funded programme are supporting people with disability and 95% are supporting people in ethnic communities, which are the two main targets of the cohorts. In many ways, we are seeing anecdotal evidence, but certainly good evidence, of different aspects of this working well.

What we are going to do is have a hub. We have brought in Eleanor Kelly, who used to be the chief executive of Southwark Council, as the COO of the deployment programme. We are putting together a hub of best practice that all local authorities can access. What is really working? Somerset is doing really incredible work with Traveller communities. Another area has been doing brilliant work with faith communities and so on. I do not have hard evidence for you but, anecdotally, it is beginning to bear fruit.

Kemi Badenoch: It is probably helpful to explain what the community champions scheme is. I am not surprised that people said they had not heard of it, because we only announced the allocations for the funding on 25 January; that is barely six weeks ago. It is not something that is expected to be in every community. This is roughly £25 million; that is not going to go far if we put it everywhere.

The purpose of community champions was to target those people who we had found just very hard to reach. I think it was Kim or Kate—I cannot remember—who was talking about those groups who may not be registered with a GP and how we find them. A lot of people assumed that this was something we were just going to put into places that had high levels of ethnic minorities, such as London or Leicester. I had an interesting question on it from Ruth Cadbury in the urgent question last week and explaining what exactly the scheme is meant to do and how we decide on the methodology. There is a range of data sources from DHSC and PHE, as well as the long-term data on Covid incidence, social integration and the needs of disabled people in the area—we are also looking at disabilities—and bringing that together to determine which places would have community champions. It is 60 local authorities.

What the scheme is also meant to do is to learn and share best practice. Where those places that we know have hard-to-reach populations have good examples of what they have been doing and what is being effective, we can share that knowledge across the country more generally. If we look at what Birmingham City Council is doing, it is funding 645 champions across 69 wards in that city. They have established a system of community partners. The Wirral is doing something interesting there, with connectors whom the local council are using. Different places will be

doing different things. What we wanted to do was give local authorities money to try something different, rather than it all just being stuff that is happening from DHSC or wherever in Whitehall, which is not really responsive to the needs of individual communities.

Q54 **Nicola Richards:** As a follow-up to that, have you engaged with any of the individuals who are already acting as community champions?

Kemi Badenoch: That is something that the local authorities would be doing. It is a scheme that is meant to be local. I would not have the capacity to do that at this stage. It might be something that we look at later on when we are doing some evaluation. As I said, we only announced the funding and where it would go on 25 January. We wanted to let people get on with doing things before we start calling them back into meetings.

Q55 **Nicola Richards:** How will you build on these relationships to address potential future community health issues?

Kemi Badenoch: That will all be inbuilt within the scheme. The local authorities will provide regular progress reports over the course of the programme. One of the next steps, as part of the bit of work that I am doing on Covid disparities, is to share the learning from the programme and to maximise the benefits from the funding. We have already started doing that. It is all built into the processes for continuous improvement and continuous learning. We are partnering with the NHS as well to host online forums for local authorities, whether they are in the scheme or not, to use our knowledge base to download resources and continue spreading best practice for engagement with disproportionately impacted and hard-to-reach groups.

Q56 **Nicola Richards:** This Committee has heard that some of the groups are suspicious of local representatives working with the Government to encourage vaccinations. What work have you done to tackle these concerns?

Kemi Badenoch: It is a really interesting question. What do you do when people are suspicious of Government and of people working with Government? Everything we do they are not going to trust. We have to just keep repeating the positive messages over and over again. We do not do things like countering misinformation and saying, "This is not true; this is the actual truth", because in countering misinformation one repeats it and also helps reinforce that there is a big conspiracy and that this is all part of it. We just continue reinforcing positive messages.

There also needs to be some realism about how much Government can do. Many people talk as if a lot of this trust is to do with Government or with actions. For many immigrant groups, lack of trust in authority is something they actually bring from the countries they come from. If you look at a lot of refugee communities and people who have sought asylum, there are lots of very serious issues that they have had with authority. We should not make the assumption that just coming to this country

means that they are going to shed that. We just have to be relentlessly positive about the work that we are doing and continue to work with the vast majority of people who do trust in Government. Eventually, it will filter through.

Where we have family members who, for instance, are not literate or do not speak a language, you find that there are other family members who do have those skills, who do have that education and who can do that sharing. People are a lot less likely to think that their family member is part of a Government conspiracy. We need to accept that there will be a limit to what Government can do in the scenario that you have described.

Nadhim Zahawi: Let me try and bring it to life for you, in terms of the work we are doing in the deployment programme. I absolutely support everything that Kemi was talking about there and learning from others. Within that community champions programme, Rotherham was focusing very much on vulnerable communities, Wakefield on faith communities, Coventry on disabled groups and Gypsy and Roma and so on.

You are right. We had a real challenge, for example, with the Hasidic Haredi community in terms of trusted voices. They came to us. They have a brilliant ambulance service called the Hatzola first-responders ambulance service, which is very much trusted by the community. They said, "Look, we can do this better than you can at NHS England, but we need your backing". NHS England, with the local authority in Hackney, backed them. We did a vaccination site for the community. On a Saturday night, at 8.30 pm, we started vaccination. I visited with Diane Abbott, who is the local MP there, and they did 364 vaccinations on that one Saturday night. It was not only the Haredi community; some of the Muslim community turned up as well. We are taking that learning and sharing it. Can we do it in Manchester with the Hatzola community? Can we do it in other parts of London with them? It is that sort of thing.

When I sat with and said, "What is the secret sauce here?" what they said is, "Because it comes from Hatzola, the families, when they get the leaflet or the call, actually pause, read it, trust it and act upon it". It is that sort of work we are doing to empower different parts of different communities that we know are trusted. It is not enough just to do that; we need to then give them the tools to vaccinate.

Q57 **Nicola Richards:** My last question is to Minister Badenoch. The Muslim Council of Britain has said that the Government refusing to work with it throughout the pandemic has had tragic consequences. What is your response to this and how satisfied are you with the Government's engagement with religious groups throughout the pandemic?

Kemi Badenoch: Who the Government engage with is based on a number of factors and is regularly reviewed on a case-by-case basis, so I am quite satisfied. The Race Disparity Unit, which is in the Equality Hub, works closely with the Places of Worship Taskforce. That includes a lot of representation from the Muslim community. Officials from there have also

met with the Muslim Women's Network, which is an umbrella organisation of lots of different Muslim women's groups, to discuss engaging marginalised women, promoting Covid vaccine uptake and disseminating the messaging.

The PM visited the Indian Muslim Welfare Society, which is the Al-Hikmah Centre in Batley. The Home Secretary visited Neasden Temple. The Communities Secretary visited the Al-Abbas mosque in Birmingham, which has been turned into a vaccination centre. We are very pleased with a lot of the engagement that we have had so far, and we can see it is making a difference.

Q58 **Kim Johnson:** My next questions are going to be on race and sex discrimination in healthcare. The first question is to Minister Badenoch. Minister, black men and women are four times more likely to die of coronavirus, as we have heard, and vaccine take-up is an area of concern. To what extent have historic health inequalities for black people led to negative outcomes during the pandemic? What steps are you taking to ensure that these inequalities are addressed in the future?

Kemi Badenoch: We have invested an additional £4.5 million of funding in new research projects, on top of the £4.3 million that I talked about in July that looks at the impact of Covid-19 on ethnic minority groups. The stats that you have read out fluctuate from time to time. What we found at the beginning of the second wave, which is changing with the data that is coming in, was that the disparity was eliminated for black groups right at the beginning. That has changed. That would not be a structural issue. A structural issue would show a consistent disparity, and that is why we are investing a lot in the research.

When we talk about health inequalities, health inequalities go both ways. There is often a lot of talk as if all the health inequalities are negative for ethnic minorities. Some of the stats that the Commission on Race and Ethnic Disparities has been looking at, as well as the RDU and DHSC, have shown that the picture is actually pretty mixed. Health inequalities manifest themselves in all sorts of different ways, just as we see with men and women, where men are more likely to die from certain things and women are more likely to be impacted by other diseases. Looking at the research and finding out what more we can learn about these diseases and about health inequalities more broadly is going to be key. That is why we are funding it.

Q59 **Kim Johnson:** I look forward to seeing the report from RDU whenever it is available. We heard from the witness panel last week that black groups are not anti-vaccination, but structural inequalities and historical medical racism has led to hesitancy, for reasons including distrust of Government and structural racism. What will the Government do to tackle the racism and discrimination that has contributed to these disparities and their negative health consequences?

Kemi Badenoch: Did they talk about where they got the evidence for that from?

Kim Johnson: Off the top of my head, I could not say right now, without going back and looking at the transcript.

Kemi Badenoch: The ONS carried out a survey. It found that the reasons for hesitancy are to do with people not trusting the speed with which the vaccine has been produced. That is across the board; the reasons are not specific to any particular ethnic group. Also, our vaccine hesitancy numbers, even for the ethnic minority groups, are still lower than international comparisons.

In terms of the issues that people refer to around historic medical racism and so on, when I have asked more deeply they often talk about things in the US, or there is one specific example about Pfizer in Nigeria that repeatedly comes up, which we do not find here. From my own personal experience, knowing the large brand that Pfizer is now, these are more topical things that people discuss, often propagated on social media, but are not the reasons for the hesitancy.

I am also very conscious about propagating a line that the NHS is racist, which is what this is fundamentally about. The medical racism that they are talking about is often to do with people interpreting the way that they are being treated as not being culturally sensitive. Having more culturally appropriate guidance and explaining to people how to deal with people from different backgrounds is something the Government are very much funding and are very much alive to.

Q60 **Kim Johnson:** The point you raise about racism in the health sector is a very complex one. There is data; if you look at maternal health data for black women, it is very alarming. The practitioners raised these issues at our witness session last week; they are working in the field and this is the evidence they provided.

Moving on to my next question, in 2020 the World Health Organization found that the UK has the largest gender health gap in the G20. What is being done to tackle sexism that exists in our healthcare system? How can we engage women in a conversation about vaccinations without blaming them for hesitancy?

Kemi Badenoch: I mentioned before that the hesitancy figures are actually not that bad for women. There is not really a sex difference, from that perspective, so I do not think that is an issue. The wider issues about women's healthcare are things that we can look at in the context of the women's health strategy, which Nadine Dorries announced on International Women's Day. This is not something we do as a one-off. There is a lot of work that has been done around women's health. Again, we are having a new call for evidence that will be gathering women's experiences and views regarding their healthcare. That is something we encourage lots of people to participate in.

Q61 **Kim Johnson:** Thanks, Kemi. I welcome Nadine's new strategy and hope we get a lot of evidence to support that.

Minister Zahawi, Kemi mentioned earlier that perceptions have changed since the rollout of the vaccinations, and we did hear last week that vaccine hesitancy is not a fluid state and does change. Would you agree with that? How easy would it be for someone who had originally refused to have the vaccine and then changed their minds and wanted to get it? How would they get it? What is your opinion on this mantra that is going around at the moment: "No jab, no job"?

Nadhim Zahawi: In terms of a second chance for a jab, the offer is evergreen, in the sense that, even if you were hesitant or did not go first time around, it is always there for every cohort that is eligible.

In terms of activity around that, that is already happening. We already have GPs talking to some of their patients who were eligible, who have had a number of contacts and have not taken them up. We have the NHS talking to their staff on a one-to-one basis; although the NHS has had a very high level of uptake in terms of front-line staff, it is repeating that process of one-to-one conversations. As I think some of your evidence suggested—we are certainly seeing it—those 10 or 15-minute conversations make a huge difference to staff.

Again, the second-chance communications to the over-70s have already been activated, with targeted messaging in terms of both press in England, with lots of press and full-page inserts in different national media, but then also quite forensic targeting as well. There is a lot of work being done around that, as well as translating all of the information into at least 13 languages, from Arabic, to Farsi, to Kurdish, to Turkish and to Polish; quite rightly, Kemi reminded us that we have to also think about those groups within what we are talking about here today.

In terms of professional duty, I would fall back on what Chris Whitty said. If you are looking after a person vulnerable to Covid, then it is your professional duty, if offered the jab, to take the jab. That is our position as a Government.

Of course, when the Prime Minister launched the roadmap with the four steps to reopening the economy cautiously and gradually, based on the data, he also announced the review that the Chancellor of the Duchy of Lancaster, Michael Gove, is carrying out, which will look at issues around duty of care if you are working with vulnerable patients, in the same way that surgeons have to do now to practise when it comes to hep-B vaccination.

Q62 **Alex Davies-Jones:** Thank you to the Ministers for joining us this afternoon. Minister Zahawi, we have seen on social media the rise in misinformation around the vaccine, particularly pertaining to fertility and issues in young women. I know you went on "Woman's Hour" to dispute some of this misinformation and I am really thankful for that. How else

can the Government counteract some of this misinformation we are seeing, which is potentially causing a reduction in the uptake of the vaccine by young women?

Nadhim Zahawi: You are absolutely right. This is completely untrue, but incredibly dangerous and potent. We stood up a unit across Government back in March last year, which was a Covid disinformation unit that works with the social networks to highlight to them any misinformation and disinformation around issues like this. The most important thing is to make sure that the clinicians are on the front foot on this. Clearly, in terms of fertility, the non-clinical evidence around all of the vaccines, whether it is Pfizer-BioNTech, AstraZeneca or Moderna, has been reviewed by our regulator. The MHRA is a world-class regulator and has raised no concerns about safety in pregnancy. Again, there are similar things in the US, Canada and Europe as well.

We are trying to do two things: first, highlight any misinformation or disinformation and deal with that; but, secondly, get the message out from trusted voices, the most trusted of which are the clinicians. You will see more of it as we begin to go down the age cohorts; you will see people like Jonathan Van-Tam, as he has done already, answer the clinical questions around this, to demonstrate that everything we do is about transparency.

It is being borne out by the polling evidence. Vaccine positivity is constantly growing, not going the other way, as people see the deployment and hear from people that look like them or are their age that it is the right thing to do. It is important that we address these issues head on.

Q63 **Alex Davies-Jones:** Minister Badenoch, you have mentioned a few times today that the data is not showing a reluctance in women compared to men in terms of the take-up of the vaccine. One of the things that my health board has told me is that, like Minister Zahawi just said, once we get further down the age groups, a refusal to take the vaccine is something they are concerned about. One of the issues they have stated to me is that that is because of vaccine take-up. Is this a concern you share? Will the Government be trying to collect this data about women of childbearing age who potentially do not want to take the vaccine for this reason?

Kemi Badenoch: That is something that will become apparent nearer the time. At the moment that is not an issue that we are particularly worried about. We know that there are more people who are susceptible to misinformation, but they will still come in within those low numbers that we were talking about broadly, in terms of the comparison between men and women.

The fertility thing is more problematic as a type of misinformation, because of where it comes from. I had a roundtable with clinicians last week, one of whom works in east London. She said about the fertility

thing that it is not social media, where we can speak to social media companies and ask them to take it down; it is the aunties. Aunts who may be less well educated or come from a different environment, growing up in a different country, advising younger people. Government cannot go into people's homes and interfere with the communication that is taking place. That is very personal.

That is why we just must keep repeating the positive messages about safety and also ensuring that clinicians have the information, as Nadhim has just said, to be able to provide comfort to those people who are seeing the doctors because they are pregnant or related to other issues around maternity, and just letting the front-line health workers do their job. It has to be from the people who are trusted as experts. It is no good Nadhim and I running around talking about fertility and saying that it is going to be safe, because that in itself will feed into the climate of misinformation. We are not the voices who are health experts.

Q64 **Alex Davies-Jones:** Are you currently obtaining the data when people refuse the vaccine and the reasons why? Is that being collated? Do we have a list of why people are refusing the vaccine?

Kemi Badenoch: That is not something the Government Equalities Office would look at. Nadhim might know more.

Nadhim Zahawi: We do not hold the refusal rates centrally, but of course we look at various data; we carry out our own research as well. It is that combination I was speaking about earlier, which is why it is important we address it. When you look at hesitancy, it is about vaccine safety and why it was approved so rapidly. Obviously, fertility plays into that safety question. It then moves on to, "The virus itself is not going to have a big impact on me because I am young and fit and healthy, so why should I take it?" You begin to unpack those different levels of questions.

Kemi Badenoch: We have to be very careful about asking for data that is going to tell us something different to what we are looking for. I have been told—I cannot remember in which meeting it was—that refusals can often be people saying, "I will take it later. I do not want to take it just now", which is not a refusal. I fall into that category, because of not being unblinded with vaccine trials. I was offered it because of other health reasons, and I said no but I would take it later, depending on what the unblinding reveals, but that goes down as a refusal. We also have to be careful that we are not collecting so much data that we are telling ourselves a different story from what is actually going on. We need to make sure the data collection is being done where it is most relevant and needed, and not speculatively where we cannot actually act on the information we are gathering.

Q65 **Alex Davies-Jones:** That is a really good point. On that point, Minister Zahawi, if pregnant women refuse the vaccine the first time around because they are currently pregnant, will they then automatically be invited for a vaccine once they have given birth? How will they be notified

to attend for their vaccine if they miss their place in the queue, for want of a better phrase?

Nadhim Zahawi: That was the thing I was mentioning earlier, about the second-chance campaign. For each cohort, as we go through, we are always going to keep returning. We now have a very big focus on cohort 6, which is about 6 million people. These are 16-to-64-year-olds with underlying health conditions, plus both registered and unregistered carers. It is a very large cohort.

As we go down the cohorts, for the one above them, the over-70s, we have already begun the recontact to say, "If you have missed your chance for whatever reason, if you wanted to wait a little bit longer, please come forward again and have your vaccination". We will constantly return to make sure we are nudging up those numbers to as high as possible. If we can get to where the ONS suggests, which is 94% of the adult population vaccinated, that is a great place for us to be.

By the way, I would just say one thing, which I will caveat by saying that we are absolutely not complacent in the vaccine deployment programme or resting on our laurels. In terms of uptake, this is the highest uptake in the history of vaccinations or any vaccine deployment in the United Kingdom. We already have very high levels of vaccine positivity, very much because the strategy has been right. We have seen, sadly, that in some other countries, where, for whatever reason, they have tripped over and then reinforced some of the negative messaging around vaccines, and that has costs lives, at the end of the day. We absolutely keep the offer evergreen.

Q66 **Alex Davies-Jones:** It is great to hear that the rollout has been so successful. One of the concerns I have been having in my inbox, as an MP, from constituents is this worry from pregnant women or breastfeeding mothers that, if vaccine passports do become a reality, they will be discriminated against because they have not been able to take the vaccine. Is that something you are able to comment on? Can you reassure them that would not be the case?

Nadhim Zahawi: Yes, absolutely. Let me just answer that question head on but in two parts. There is an international element to this. We are already seeing countries saying that they will introduce a form of vaccination passport or vaccination certification, as well as, of course, testing certification. We require a pre-departure test; lots of other countries require proof of pre-departure tests. As far as international travel is concerned, we are leaning in and Grant Shapps, Secretary of State for Transport, wants to be able to shape the protocols around that, to make them as advantageous as they can be for our own citizens, whether you are travelling for business or for leisure.

Domestically, it raises many issues that are difficult and challenging, including discrimination, ethics and privacy, which is why the Prime Minister has tasked Michael Gove to review this and to report before 21

June on this, so that we have an informed decision-making process, rather than acting in haste and getting it wrong. It is important that we await that review. We can then come back to your Committee and will be very much able to discuss that.

Q67 **Alex Davies-Jones:** That is useful to know. Moving on now and looking to the future and what more we can do for vaccine trials and treatment for pregnant and breastfeeding women, are the Government planning on funding any more of these vaccine trials or treatment plans, specifically with breastfeeding women and pregnant women as part of the trial, or with them in mind?

Nadhim Zahawi: At the moment, there are a number of trials that both the manufacturers but also the Government are funding. The Vaccine Taskforce at the moment has out about £7 million into what is called a mix-and-match trial, so that you have a first dose of one vaccine and a second dose of another vaccine, such as Pfizer and then Oxford-AstraZeneca. In the Budget, the Chancellor also, as part of his announcement of an additional £1.65 billion for the vaccination programme, announced additional funding for more trials, including a third dose or a booster dose of the vaccine. All of that is ongoing.

There is no safety data around pregnant women, but there is also no reason to suggest that the vaccine will have an adverse effect on pregnant women. The advice is very clear from the regulator: if you are pregnant, you have the conversation with your clinician to make sure those issues are addressed and that, if you need the vaccine, you take the vaccine with that advice.

Q68 **Alex Davies-Jones:** On a wider point, how are the Government encouraging more black, Asian and minority ethnic groups to engage in the medical and vaccine trials. Probably, Minister Badenoch, you are best placed to answer this given that you are going through them at the moment.

Kemi Badenoch: I have alluded to it at several points during this session. It is part of our strategy. We target people through all sorts of different channels with messaging: we have done videos; we have had social media influencers talk about these things. The key thing is to ensure that it is normalised and does not feel like something weird or strange, but actually a very normal thing that happens all the time. Because of what has happened with Covid, many people, across all groups, have only just realised the huge scale of trials and registered for trials that existed before. It is not something that many people have really been aware of.

The general information will help, but at the moment, given where we are with the successful production of vaccines, I am hoping we are pivoting more just to ensuring that people take them. There will be many lessons learned from this that will be useful for loads of other diseases and initiatives that we have in the long term.

Nadhim Zahawi: Very briefly, one of the real advantages of what Kate Bingham and the team delivered under the Vaccine Taskforce, with the backing of Matt Hancock, is this huge database of volunteers who have come forward. If I am not mistaken, it is about 500,000 people for a clinical trial basis, which is enormous, including Kemi and myself on the Novavax trial. It gives us, in many ways, another unique advantage in terms of attracting the life science community to come and do trials in the United Kingdom.

Q69 **Bell Ribeiro-Addy:** Thank you very much, Ministers. My first question is to both of you. We have seen the type of disinformation varies depending on the group it is being circulated to. For example, Hindu and Muslim communities were told disinformation about the vaccine containing meat and alcohol; in black communities, we saw historical injustices being exploited by anti-vaxxer groups to garner more vaccine hesitancy; false reports about the vaccine leading to infertility created fears amongst young women. What actions have the Government taken specifically to reduce this Covid-19 disinformation targeted at BAME groups and young women in particular?

Kemi Badenoch: I would not go into a lot of the detail about what is being done, because that is not helpful; if people know what we are doing, they can counter it. More broadly, we know it is being shared online. We do a lot of work with the social media companies. We are also very specific about what we are talking about. Misinformation and disinformation are not the same thing, so they are tackled differently. Being anti-vax is different from vaccine hesitancy.

All of these things have different strategies that we look at. Some of it will be around the platforms where they are shared. Some of it will be with the clinicians themselves who are able to provide accurate information because they are on the front line. Some of it will just be generic information that the Government are putting out through the channels that I discussed earlier.

People need to get accurate information about Covid; that is the key thing. We need to make sure that our sources are trusted, which they are. The NHS website, for example, is the most trusted place when it comes to getting health information; that is where people go. There is a limit to what we can do in things like WhatsApp groups, for instance, which are encrypted, so we need to make sure that for those people who are in those chat groups, they can go to the NHS website, for example, and get the right information.

Nadhim Zahawi: It is a really important question. One of the things we secured back on 3 November, from Facebook, Twitter and Google, is that no company should profit from or promote Covid-19 anti-vaccine misinformation and disinformation, and of course they should respond rapidly when we flag up. Do you remember I mentioned the unit across Government that is at the Cabinet Office, with a lead at DCMS, which

looks at and flags this information? That was an important agreement with the networks.

You mentioned the Bangladeshi community. I can look at my own background and my and my wife's family from the Middle East. Much of this disinformation is very cleverly, super-forensically targeted at different communities. Our comms strategy has been really clever at essentially engaging with and partnering with, as Kemi mentioned earlier, those media outlets, whether it is Middle Eastern television channels or Bangladeshi or Asian television channels. I can tell you from first-hand experience, from my parents and other relatives, that they have seen our messaging as well in those languages. We are coming at it in lots of different ways, to make sure we get the positive information out rather than engage in the negative disinformation.

Q70 **Bell Ribeiro-Addy:** Just touching on what you are doing with outside actors, do you think social media companies are doing enough to tackle Covid-19 disinformation campaigns online? How exactly are you working with them on this? You touched on how you are working with Google, but what specifically are the social media companies doing? That question is for Minister Zahawi.

Nadhim Zahawi: I mentioned Google, but it is equally applicable to Facebook and its different platforms, and Twitter as well. They are absolutely engaged in this with us. We got their agreement that none of them will allow profit to be made from people posting or buying content to promote Covid anti-vax misinformation and disinformation. More important than that, we got their commitment that they will respond rapidly when it is flagged to them. Obviously, they have duties towards free speech and so on, but if it is fake, they will take it down.

Q71 **Bell Ribeiro-Addy:** I have one final question for both of you. There has been a lot of foreign vaccine disinformation. That has proved to be quite impactful and dangerous in fostering fears about the vaccine, with people talking about which one they would like because of stories they have heard about it. What steps are the Government taking to tackle this foreign disinformation?

Kemi Badenoch: I do not think we should look at disinformation that is coming from outside the country as being different from the sort that is originating in the country. It goes back to what Nadhim said about it being targeted. If you are someone who is Nigerian, you will have relatives in Nigeria who you are probably in touch with. You will get information that comes from that country. The same is true if you are of an Indian or Pakistani background, and so on.

We have worked with ambassadors, for example. That was something I did last year, where we wrote to lots of different embassies that have large diaspora communities, letting them know about the work we are doing, so that they can share this within their networks. There is again a

limit to what we can do outside our country, but we can work with our partners as and where we have them.

Again, I would just really explain to the Committee that the belief that Government can do everything needs to be challenged. People need to take personal responsibility; everybody needs to take their own personal responsibility. They cannot wait for the Minister to fix vaccine disinformation that is happening within their WhatsApp group. We are never going to see it. Neither is the social media company or the telephone platform. It is about reinforcing the message that everybody has their responsibility, whether you are a family member, a journalist, a clinician, a teacher or a local politician.

We as MPs also have a responsibility to tackle some of this. I have given repeated examples where MPs, for political purposes, end up using vaccine misinformation phrases that are unbelievably unhelpful. We need to be serious and lead by example as well.

Nadhim Zahawi: All I would add is that, if it is coming through foreign states, we have the rapid response unit I talked to you about earlier, which not only flags but also, if necessary, responds directly on social media. Those efforts are supported by our national security communications team with the Army 77th Brigade, which is expert at tackling disinformation from hostile state activity. I do not know if that is where you were heading with your question.

Q72 **Elliot Colburn:** Nadhim, there is just one question from me to you, which is about the work the Government are doing with NHS trusts to tackle vaccine hesitancy among NHS staff in particular, and whether or not the Government have done any kind of impact assessment or considered the likely impact if a disparity in vaccine uptake continues among, for example, women or BAME groups within the NHS?

Nadhim Zahawi: Among frontline healthcare, the uptake has been incredibly high; it has been over 90%. The NHS is not sitting back and feeling happy with that; it is revisiting. As Kemi quite rightly reminded us, we have to be careful how we interpret the data, but if, for whatever reason, people have not had the vaccine, there are one-to-one conversations with people, just to understand better. The NHS is brilliant at doing that. It has done it before. When I talked to the head of HR around PPE and safety, they did one-to-one interviews with over a million NHS workers in a six-month period last year. There is pretty incredible care and support for their staff. That is going incredibly well.

We want to make sure the same thing happens across the social care sector as well. If you look at some of the SAGE recommendations, in residential care homes for the elderly, we are already well above 90% in terms of the eligible residents who have had the vaccine; if they had the virus, we have to return to them, as I described earlier. We want to get up to over 85%, to get that protection, according to SAGE. We look at all this data. Through our communication and through giving access to the

vaccine at a time and a place that is both convenient and trusted, I am confident that we will get there.

Q73 **Angela Crawley:** Minister Zahawi, are vaccine passports likely to become a reality? Have the consequences for the BAME community been considered?

Nadhim Zahawi: I addressed that question earlier. Internationally, we are certainly seeing a number of countries, whether it is Cyprus, Greece or others, already announce a requirement for travel, in the way people have in the past required a yellow fever vaccine certificate or passport to be able to travel to certain countries. We want to facilitate that, make it easily accessible for our citizens and also shape it. It is right that Grant Shapps wants to lean in and make sure that, if it is going to happen rapidly, which looks like it is about to happen, it happens in a way that is advantageous to our citizens. After all, we are one of the lead large countries that has been vaccinating at scale now since December of last year.

Domestically, it raises a number of difficult issues, including, as you say, making sure that all of our citizens have had the offer of the vaccine, but also issues around discrimination, which you have quite rightly touched upon. There are a number of areas that it is right for Michael Gove to look at very carefully, including privacy. We want to have that review done properly before we make any sort of decisions on this.

Q74 **Angela Crawley:** The Committee has heard, though, concerns that the vaccine passports could cause further distrust of the Government for BAME groups. What is your response to this?

Nadhim Zahawi: It is why we want to have a review. We want to make sure we talk to every group and all stakeholders on this, which is pretty much all of us. Internationally, if countries are going to demand it, it is only right, and it is the responsibility of any Government, to make sure that we facilitate that in a way that is easy to use but also anti-fraud and all the other stuff that needs to be done operationally. That is being looked at.

We also want to shape it globally. It is much better that we have our input and shape whatever the protocols are around this, and get them right, than for them to happen without us at the table.

Kemi Badenoch: Yes, absolutely. I completely echo what Nadhim has said. I would also remind the Committee that vaccine passports are not a new thing. Those of us who are much older will remember yellow fever certificates and things like that still being demanded across Africa, for instance. From the international perspective, I am less worried about people being mistrustful of the Government, because it will be standard. As Nadhim said, if this is something that is going to happen, it is better that it is done by the UK, where we have extremely high standards and

look at ethics and equality impacts in a way that many other countries do not.

Q75 **Chair:** Can I just pick up on something Nadhim just said about a review on vaccine passports? How long do you anticipate that will take? Is there a danger that, in reviewing what we want, we might miss the opportunity to shape what happens globally?

Nadhim Zahawi: I just want to be clear about that. The global element is moving forward. There is no review around that. We are basically wanting to shape what that looks like and make sure that its protocols are as advantageous as we can make them for our citizens. That is happening; Grant is leading that for us.

Domestically, there is a review that will report before 21 June, which is step 4 of the four-step plan to reopen the economy and get our lives back. That is looking at all these difficult issues around how and if you would introduce an enhanced test or vaccine certification programme to be used domestically. We know, for example, testing technology is getting better and better and faster and faster. For things like mass spectator sport, there is going to come a moment. We have massive testing capacity; I think we have just done over a million tests a day, which we just hit yesterday, and of course we are vaccinating at speed. All of that raises a number of issues, which I know your Committee is going to be interested in, which is why the Chancellor of the Duchy of Lancaster is reviewing it before 21 June.

Q76 **Chair:** You have just referenced a million tests a day. I am very conscious that back in February there was a lot of ministerial rhetoric about March being a bumper month for vaccination. The numbers are not bearing that out, are they? What are you planning to do in the second half of the month to speed things up?

Nadhim Zahawi: You are absolutely right to probe that further. You will see, I hope by the end of this week, the numbers begin to climb again. I am very confident that the second half of March will be, as the Secretary of State for Health described it, a bumper month. We have reasonably good visibility of our supply for April as well. As Simon Stevens described it in the presser with the Prime Minister a few weeks ago, if you do the numbers, to get to 32 million cumulatively by mid-April for groups 1 to 9, which is the over-50s, in phase 1, we need to double the rate of vaccination, because we are doing second doses as well at the same time. Those who had their vaccine in January will now be due their second dose in March. I am confident you will see those numbers begin to climb to everybody's, I hope, joy and satisfaction.

Q77 **Chair:** I have a final question for Kemi, please. This morning we saw the publication of statistics from the ONS about the impact that the pandemic had had on women in particular. Is it still the correct strategy to look at policies in the round, or should we be targeting them?

Kemi Badenoch: I think it is correct to look at policies in the round. We take these things into consideration, but we cannot have policies that are exclusively based on gender for a pandemic that is impacting so many different people in different ways.

Nadhim Zahawi: I have one tiny correction that, quite rightly, Antonia pointed out to me. I mentioned the clinical trials database; it is actually 455,000 that was achieved, which I think is still an incredible achievement by the Vaccine Taskforce under the leadership of Kate Bingham.

Chair: Thank you for that clarification, Nadhim; it is much appreciated.

Q78 **Ben Bradley:** I have a quick question. It is something that just came to me from part of the discussion about the conversation about challenges in terms of women's hesitancy in accessing the vaccine. It is something I have spoken to friends and colleagues of mine about, around some of the men's issues in relation to that. Earlier on in the process, when masks were first introduced on public transport, if you were on the tube in London it often seemed to be young men who did not have them and who were not compliant with that. Particularly for young men, there is also this challenge that Nadhim touched on earlier about young, healthy, fit people thinking, "Do I really need to have this vaccine?" We have seen some discussion about whether it protects you from spreading it to other people.

There is a concern there about how you reach out to younger men and women who may be thinking that way, thinking, "When it comes to my turn, do I really need to bother with this?" I know it is something that a lot of my friends have said: "If it is not going to protect me from spreading it to other people, then what is the point?" Is that something you have come across?

Kemi Badenoch: I have given an example of this before. You might have seen the videos where we showed young people who were playing in a playground and they are going to see their nan or they are going to see other vulnerable people. One of the things we have tried to reinforce in the messaging is that it is not just about you. Wearing a mask is not just about looking after yourself; it is about protecting other people. We have tried to put that in the messaging. It is about people who live in multi-generational households, for instance.

We have really emphasised in the guidance that it is not just about you being fit and healthy. We have been letting people know that being asymptomatic is also one of the difficulties of Covid: with many other diseases, if you were sick you would just stay at home; the problem with Covid is that lots of people are superspreading it and have no idea that they have this disease. Emphasising this message is really important.

It touches on the point that Caroline asked earlier about the way things impact women economically. It is why we have to look at things in the

round. If we look at everything specifically within one lens, we will miss so many things. It is just a lot harder to do with the resources that we have. We have to use the resources we have effectively. Things that impact people more broadly, looking at young people—it is not just young men, but it will have an impact on men—and their attitudes to Covid is absolutely critical in terms of how we tackle the response and levels of compliance.

Q79 **Ben Bradley:** I raise it as a men's thing because we know the stats suggest that men are at slightly higher risk in terms of the illness. In line with the masks thing, I very much get the impression that there is almost this kind of macho denial attitude in some places. I have seen young lads who say like, "I am not wearing a mask," or, "I do not need that vaccine. I am fit and healthy," or whatever. Is that something where there is a particular targeted message or a particular medium we need to use to reach those guys, or whatever it may be, which might be different to some other groups?

Kemi Badenoch: I cannot think, off the top of my head, what we would do beyond perhaps using male social media influencers or channels, such as men's magazines. I do not know how much people are doing that during the pandemic. It is a good point. I do not think I have an example, and that is a group that may need some specific messaging. I can ask officials to take it away and make sure it is fed into our comms plan. It is a good point that you raise.

Nadhim Zahawi: It is a really important point. As we get more and more positive data around the impact of the vaccination programme on transmission, that will also play into that narrative, i.e. you are doing it because you are going to protect your family, your friends, their family and your community. We are launching, with a DCMS lead on this, a social media toolkit for opinion formers and opinion leaders in their communities. I think Thursday is the launch. That is only a start; as Kemi said, we will look at that and keep improving that as we go on.

It is worth reminding the Committee, if you do the numbers, to do the 32 million cumulatively for phase 1, that is 64 million doses. We have done 22.8 million to date, so we are only one-third of the way. We have to keep going at pace, but we also have to remember that we are only a third of the way through phase 1. We need to keep refreshing and flexing our messaging as we see the evidence emerging, so that we get, ultimately, to where we all want to get to, which is 94% or 95% of the adult population being vaccinated.

Q80 **Kim Johnson:** Nadhim, your team has done an amazing job and the amazing NHS has done an amazing job in terms of pushing out this gargantuan ask. The vaccination programme has been a massive success. My question, Nadhim, is about regional variations in terms of supply. That was an issue quite early on. I do not know whether that continues to be an issue.

Nadhim Zahawi: In the second half of March you will see a big uplift in supply, which helps. Up until now, supply has been finite. We have had good volumes, but when your supply is finite you have to try to make sure that each region gets enough doses to do the cohort target. When we were focused on 1 to 4, which is 88% of mortality, by the middle of February, we had to make sure that each region had that vaccine available to them.

As we receive more—I am expecting tens of millions of doses to come through—that becomes a little easier, which allows us to, for example, double the number of pharmacies that will come online for delivery. We have over 200 already delivering. They have been proven to be incredibly effective, especially at reaching the groups we have been talking about today, because they are very much part of the community in the way GPs are as well. We are about to double that number by the end of March. I am confident we have big numbers.

Kim, I am hopeful that not just your constituency but the whole country will see a rapid increase in the number of people getting their first dose and getting protected, while we do the second doses at the same time.

Kim Johnson: Thank you, Nadhim. I am really pleased about the rollout of the pharmacies, because at the moment we only have three in Liverpool. I look forward to seeing more being established.

Chair: Can I thank you both, and Antonia, for your evidence? It has been hugely appreciated.