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Contents

Summary	3
Introduction	4
Conclusions and recommendations	5
1 Part 1 – Securing the UK’s access to potential vaccines	9
Securing access to potential vaccines	9
The Vaccines Taskforce	10
Ensuring vaccine supply	12
2 Part Two – Deploying the vaccines	14
Getting the vaccines to the right people at the right time	15
Local distribution	16
3 Part Three – Public confidence and communication	18
Expectations for the vaccines programme	18
Expected take-up of the vaccine	19
Communication about the vaccine programme	19
Formal minutes	21
Witnesses	22
Published written evidence	23
List of Reports from the Committee during the current Parliament	24

Summary

Government acted quickly to put in place a vaccine programme in response to the COVID-19 pandemic, including supporting the development of potential vaccines, striking deals with pharmaceutical companies and starting to vaccinate some of the most at-risk members of society. We commend the work of the Vaccines Taskforce in identifying the vaccines to back and supporting scale-up of manufacturing; the Department for Business, Energy & Industrial Strategy for purchasing vaccines, and the Department for Health & Social Care, NHS England and NHS Improvement and Public Health England for launching the largest vaccination programme in the UK's history. At the point of our evidence session, 2.5 million of the most vulnerable people across the UK had received at least one dose of a vaccine against COVID-19 and as of 10 February 2021 more than 13 million doses had been delivered.

Despite this significant achievement, there is still much to be done to meet the Government's target to offer a vaccine to 17.7 million in priority groups by the end of April 2021, with supply a key factor. We are concerned by Departments' lack of planning for the next phase of the programme and in learning the lessons from what has already been done that will be so vital to the programme's success. While the Department for Business, Energy & Industrial Strategy, through its Vaccine Taskforce, has needed to work at pace, it has not quite struck the right balance between making decisions quickly and maintaining transparency over how those decisions are made and there remains some uncertainty over key issues.

Government has at times struggled to communicate clearly to the public about what they can expect from the vaccine programme, otherwise it risks confusion about who will be able to access the vaccine, how and when. With misinformation about vaccines being circulated on various digital platforms, clear communication from government is particularly important to maintain public confidence and take up. High global demand for those vaccines that have been approved means it is vital government builds on the momentum to date if the vaccine programme is to be a success and have offered a vaccine to all those who want one by autumn 2021.

Introduction

The COVID-19 vaccination programme is a cross-government effort to secure access to effective vaccines and to administer them to the population. The Department for Business, Energy & Industrial Strategy (BEIS) is responsible for securing the supply of vaccine for the UK. BEIS established a dedicated Vaccine Taskforce in April 2020 to help achieve its aims. The Department for Health & Social Care (DHSC) is ultimately responsible for planning how to deploy the vaccines in England. NHS England and NHS Improvement (NHSE&I) is responsible for designing how to deliver the vaccines and providing staff, and Public Health England (PHE) for arranging storage and distribution.

At the time of our evidence session, BEIS had signed contracts with five pharmaceutical companies to provide access to 277 million potential doses. The first vaccine against COVID-19 approved for use in the UK on 2 December 2020 was developed by Pfizer Inc and BioNTech SE. NHSE&I started to administer the vaccine in England on 8 December 2020. Further vaccines developed by the Astra Zeneca Limited—University of Oxford partnership and Moderna Inc were also approved for use by the MHRA on 30 December 2020 and 8 January 2021 respectively, a commendably fast approval.

The Joint Committee on Vaccination and Immunisation has advised nine groups should receive priority access to the vaccine. NHSE&I aims to vaccinate around 12.2 million people who make up the first four priority groups by 15 February 2021. It plans to offer a vaccine to the remaining five priority groups (17.7 million people) by the end of April, with everyone who wants one offered a vaccine by Autumn 2021.

Conclusions and recommendations

1. **BEIS, NHSE&I and PHE have made major and world beating progress in buying and starting to roll-out the vaccines, but a degree of uncertainty remains in key areas.** By 4 January 2021, some 2.3 million of the most vulnerable people in England had received at least one dose of a vaccine. By 10 February the Government's own figures are that in the UK, 12,646,486 people had received a first dose and 516,392 people had received a second dose of vaccine.¹ This is a significant achievement. We applaud the rapid establishment of the Vaccine Taskforce and we commend the efforts of everyone involved in delivering the vaccine programme to date. But the hard work is not over yet. There remains uncertainty over important areas such as: whether the vaccines stop the transmission of COVID-19; whether an annual vaccination programme will be necessary; and the reality that the virus has mutated so the vaccine programme must adapt and respond as more is learnt about the challenges ahead. There is also a strong case for asking the Joint Committee on Vaccines and Immunisations to look again at which groups should be prioritised after the most vulnerable groups have been vaccinated, especially front line key workers who are more exposed to community transmission than other groups. BEIS does not currently consider planning for the possibility of an annual vaccination programme to be an urgent or critical question owing to the number of potential doses the UK has access to. However, there is no guarantee that all of the vaccines it has signed up for will be approved or delivered, creating uncertainty over whether further vaccine purchases will be needed and how BEIS will manage potential excess doses it has committed to buying.

Recommendation: *To ensure that the momentum and progress to date is not lost, by March 2021 BEIS, DHSC, NHSE&I and PHE need to have in place plans to respond to potential future developments such as: changes to the prioritisation list; an annual vaccination programme; or the discovery of new variants of the virus.*

2. **Despite BEIS's confidence, concerns remain over the vaccine supply chain.** Under the Government's ambitious plans, everyone who wants a vaccination should be able to have one by Autumn 2021. This will depend on continuing vaccine supply. Whilst BEIS asserts that the UK has access to more doses than it likely needs if they all work, NHSE&I is less certain when the doses will arrive. BEIS holds detailed supply schedules up to the end of February 2021 but until recently NHSE&I was only able to provide vaccination sites with supply schedules one week in advance. There have been conflicting statements about vaccine supply. BEIS is unequivocal that supply will not be a constraint in meeting the Government's 15 February target and on current numbers this appears to be on track. The Department is confident that, through its investment of £302 million, of a potential £519 million, in the UK's manufacturing capacity, the UK could manufacture all the vaccine doses that it might need should this contingency be required. Yet on the same day we took evidence the Secretary of State for Health and Social Care stated that supply of the vaccine is the 'rate limiting factor' for deployment plans.

1 Latest figures can be found at: <https://coronavirus.data.gov.uk/details/vaccinations>

Recommendation: *BEIS should, by the end of February 2021, write to the Committee with its assessment of the risks within the vaccine supply chain and a plan to proactively address these to ensure sufficient doses of vaccine are available through to Autumn 2021.*

3. **BEIS has worked quickly to secure access to vaccines but could have been more transparent about how decisions have been made.** Transparency is essential to maintain public confidence and ensure taxpayers' money is being well spent. BEIS has managed significant uncertainty and worked at pace to purchase vaccines, but it could have been more transparent about how key decisions were made. The Chair of the Taskforce was appointed directly by the Prime Minister. While we recognise that a full competition was not an option at the height of the pandemic our witnesses could not explain why she was chosen or the reasoning behind the appointment which appears to be a personal decision by the Prime Minister. Transparency and openness about such key appointments is important and helps hold decision makers to account.) Almost a fifth of the 200 individuals on the Taskforce have recorded at least one conflict of interest although most are minor. To ensure the UK could access vaccines once they were approved, BEIS has made £914 million worth of upfront payments to enable pharmaceutical companies to start manufacturing vaccines at scale, but this could be lost if the vaccines are not approved. It has also agreed to provide each pharmaceutical company with broad ranging indemnity cover against adverse effects arising from their vaccine. In evidence witnesses were clear that had the indemnities not been provided this would have put the UK behind other countries in securing vaccines.

Recommendation: *BEIS should, by the end of March 2021, review its decisions about how to invest taxpayers' money and its appointments processes to identify what it would repeat and what it will change in future. As part of this, BEIS should examine its experience of using the Taskforce model to inform its own and government's future skills requirements and to ensure accountability arrangements are robust. BEIS should, by the end of April 2021, lay out its learning so the rest of government can improve the robustness of the cross-government emergency response. It should also assess how it will deal with indemnities for future vaccines and be clear about the benefits and risks.*

4. **DHSC, NHSE&I and PHE will continue to face significant challenges in making sure they can get the vaccine to the right people at the right time.** Each vaccine will require different plans for deploying because each has different characteristics. Getting the vaccine to the right place to allow it to be administered is challenging. For example, the Pfizer Inc and BioNTech SE vaccine must be stored at -70°C, whereas the vaccine developed by the Astra-Zeneca Ltd—University of Oxford partnership can be stored at between 2°C and minus 8°C. BEIS considered the logistics of deployment as part of deciding which vaccines to purchase but prioritised whether the vaccine itself would work. Despite these challenges, 97.3% of vaccine deliveries so far have been made on-time and in full. The Former Chair of the Taskforce explained that the MHRA had compressed parts of the process while ensuring the efficacy and safety of the programme. NHSE&I is working to ensure any surplus vaccines are redistributed to those areas most in need and is using large vaccination sites and community pharmacies to help smooth distribution at a local level. NHSE&I is

confident that it has in place the workforce it needs to meet its 15 February target, with around 80,000 people trained and ready to administer vaccines. Convenience and location of vaccine centres will be important in encouraging people to take up the offer of a vaccine, particularly in hard to reach groups. We were informed that 21 mobile army units of 101 Logistics Brigade were deployed. Local GPs and community leaders will play a crucial role in making sure people are willing and able to take up the offer of a vaccine and PHE has committed to working with local government to ensure that no community gets left behind.

Recommendation: *By the end of February 2021 DHSC, NHSE&I and PHE should write to us with their assessment of the main challenges and risks to the ongoing deployment of the vaccine programme and a detailed plan for how these will be addressed.*

5. **There is a risk that NHSE&I and DHSC's plans for the vaccine programme will not meet public expectations.** NHSE&I recognises that its goal to vaccinate the first four priority groups by 15 February is a huge task which it appears to be on track to deliver. As no-one can be forced to have the vaccination, NHSE&I will determine the programme's success based on the number of people offered a vaccine rather than the number of people who are vaccinated. The daily vaccination totals published by government, however, are based on the number of vaccines administered, not offers made. We are concerned that using these could create confusion among the public about progress with the vaccine programme. NHSE&I has lengthened the time between individuals' first and second doses of the vaccine from 3 to 12 weeks. It asserts that this delay is not linked to the introduction of new lockdown measures, but "basic maths" that it is better to have more people with single dose protection than a smaller number with double dose protection. NHSE&I currently expects around 25% of people will not take-up the offer of a vaccination but is hopeful that actual take-up rates will be higher. We are nonetheless concerned about how vaccines will be deployed across parts of the country with different age demographics, local need and people with vulnerabilities. NHSE&I recognises that there is a trade-off between equity of access and the speed of deployment and that it cannot allow one part of the country to race ahead of another.

Recommendation: *NHSE&I and DHSC need to immediately set out in detail what they are planning to achieve so the public has a better understanding of what the daily progress reports mean in practice. It should clearly set out: the definition of 'vaccinated' and 'offered a vaccination'; and expected take up rates across both doses and across different cohorts, for example by age and ethnicity. Progress should also be reported at local, regional, devolved and UK levels in a consistent and comparable way.*

6. **Public confidence in the vaccine programme is crucial to its success yet some members of the public and health professionals were confused by the messaging about when and how people can access a vaccine.** The number of people who choose to have the vaccine will ultimately be determined by public trust in the vaccines. Clear communication is essential to enable the public, Parliament and health professionals understand what is going on within the vaccination programme, but is challenging because the situation is evolving so rapidly. We have previously found that a lack of information during the pandemic, or repeatedly changing and

updating guidance, can be confusing and frightening for those affected. NHSE&I had not yet developed a Frequently Asked Questions section for its website at the time of our evidence session nor has it put in place a rebuttal unit to deal with negative publicity or fake reporting about the vaccines. NHSE&I acknowledges it needs to be vigilant about the potential for fraudsters to take advantage of the more vulnerable in society in offering fake vaccines.

Recommendation: NHSE&I and DHSC need to immediately develop clear and straightforward communication, including comprehensive FAQs, to help the public navigate the constantly changing situation. This should be publicised to the public and those who can help inform the public such as GPs, Clinical Commissioning Groups and MPs, as well as setting up a unit to quickly rebut false claims about the vaccines.

1 Part 1 – Securing the UK’s access to potential vaccines

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department for Business, Energy and Industrial Strategy (BEIS), the Department of Health and Social Care (the Department), NHS England and NHS Improvement (NHSE&I), Public Health England (PHE) and the former Chair of the Vaccine Taskforce, on the government’s preparations for potential COVID-19 vaccines.² The evidence session took place on the 11 January, our report is based on the evidence that we took at the time.

2. The COVID-19 vaccination programme is a cross-government effort to secure access to effective vaccines and to administer them to the population. BEIS is responsible for securing the access to potential vaccines for the UK, Crown Dependencies, and Overseas Territories. This includes supporting the research and development of potential vaccines; deciding which vaccines to purchase; buying enough doses of vaccines; and developing manufacturing capacity within the UK. The Department is responsible for planning how to deploy the vaccines in England. Northern Ireland, Scotland, Wales, the Crown Dependencies and Overseas Territories are responsible for deploying the vaccine to their own populations. Within England, NHSE&I is responsible for the operational delivery of deployment activities, including: developing delivery models; identifying those who are eligible for a vaccine and inviting them to an appointment; and making sure vaccination sites are ready on time and have sufficient clinical and support staff available. PHE is responsible for taking delivery of COVID-19 vaccines from the pharmaceutical companies and distributing supplies onwards to vaccination sites.³

Securing access to potential vaccines

3. Government had to work at pace and without any certainty that an effective vaccine would be found. Vaccine development typically takes a minimum of 10 years and in June 2020 BEIS estimated the likelihood of a successful vaccine being developed, delivered on scheduled and successfully deployed within the UK to be between 36% and 77%. BEIS worked to an accelerated timetable to make a vaccine available within 12–18 months. By November 2020, BEIS had signed contracts with five pharmaceutical companies, providing access to 267 million potential doses at an expected cost of £2.9 billion.⁴ BEIS told us that, since the NAO report, it had signed contracts to provide access to a further 10 million doses. It also told us that, by January 2021, the UK had secured access to 367 million doses from seven vaccine developers with four different vaccines.⁵

4. In our report on Government procurement and supply of personal protective equipment during the pandemic, we found that working at pace and using emergency procurement procedures had created significant risks and led to a lack of transparency about, and failure to maintain proper records of, key decisions.⁶ We similarly concluded

2 C&AG’s Report, Investigation into preparations for potential COVID-19 vaccines, HC 1071, Session 2019–21, 16 December 2020

3 C&AG’s Report, para 2–3

4 C&AG’s Report, para 9, 15, 1.4, 2.1, Figure 1

5 Qq 32, 36, 73, Department of Health and Social Care, [UK COVID-19 vaccines delivery plan](#), 13 January 2021

6 Committee of Public Accounts, COVID-19: Government procurement and supply of personal protective equipment, HC 928, 10 February 2021

in our report on the supply of ventilators during the pandemic that despite having to operate at speed, Departments still had a duty to carry out full due diligence for all parts of the supply chain as part of procurement.⁷ In order to make faster decisions and increase the chances of purchasing vaccines, BEIS, HM Treasury and the Cabinet Office made changes to how investments were approved. This included increasing the amount of investment that BEIS could approve internally, reducing the amount of time allowed for investment decisions, and creating new structures to speed up approving expenditure over £150 million.⁸ The Taskforce's due diligence checks on potential vaccines did not compare potential vaccines against a common quantitative scoring mechanism, making it more difficult to compare how each vaccine was selected. Officials told the NAO that this was because Ministers took decisions on a rolling-basis as information became available and it was not possible to compare different vaccine types in real-time. We recognise this because the priority was speed. BEIS recognised, however, that this approach would be more applicable to a future vaccination programme.⁹

5. Given the context it was negotiating in, BEIS had to invest some money that may have to be written off if the vaccines purchased are not used. It agreed upfront payments worth £914 million in the five contracts signed up to 8 December 2020, before any of the vaccines had been approved for use.¹⁰ We asked what risk this approach posed to taxpayers' money. The former Chair of the Taskforce accepted that the risk was substantial as securing access to vaccines had required taking on costs before they knew whether or not those vaccines were safe and effective. She explained that these payments were nonetheless necessary to allow the companies producing the vaccines to invest in the manufacturing capacity needed to produce the vaccines quickly if they were approved.¹¹ BEIS confirmed that, had it not made payments upfront, the vaccines would not have been available as soon as they were approved and the programme would have been delayed.¹²

6. The taxpayer may incur additional costs in future because BEIS' contracts with pharmaceutical companies include indemnity protection against liabilities and legal action that could arise in the event of adverse effects from the vaccines. BEIS rejected requests for complete immunity, but in four of the five contracts agreed by December 2020, it had not set a cap for the amount of money that government could claim in the event of a successful claim. It accepted that its agreements were "fairly broad" but was unable to provide further details in a public session. The former Chair of the Taskforce told us that providing the indemnities "was not a choice" and if BEIS had not, the UK would not have secured the access to the vaccines that it had. The Department explained that offering indemnities during emergencies was not necessarily unusual, and it had done so during the swine flu epidemic.¹³

The Vaccines Taskforce

7. BEIS created a Vaccines Taskforce (the Taskforce) in April 2020 to support the research and development of potential vaccines, select which vaccines to purchase, secure the UK's

7 Committee of Public Accounts, CPVID-19: Supply of Ventilators, HC 685, 25 November 2020

8 Q 33, C&AG's Report, para 20–21, 3.8–3.10

9 Q 33, C&AG's Report, para 10, 1.6

10 C&AG's Report, para 16, 2.5

11 Qq 42–43

12 Q 43

13 Qq 47–49, C&AG's Report para 17, 2.8–2.9

access to sufficient quantities of vaccines, and develop manufacturing capacity to ensure supply.¹⁴ It explained that creating the Taskforce allowed it to very quickly give a potential vaccine the senior focus, governance and skills needed to respond to the pandemic.¹⁵ The Taskforce consists of pharmaceutical industry experts, academics and civil servants from across government. At December 2020, the Taskforce had 201.7 full-time equivalent staff, including 79.9 full-time equivalent staff recruited from outside the civil service. We asked how BEIS was ensuring that it was able to keep hold of, or ensure access to, the skills and expertise it needed. It responded that to date it had not encountered any problems with this as the best way to motivate and retain people was to give them something that really mattered to work on and the issues the Taskforce was dealing with was the “absolute No.1 national priority”.¹⁶

8. The Chair of the Taskforce took up the unpaid post in May 2020. The Chair was appointed by, and reported directly to, the Prime Minister until the term expired at the end of 2020.¹⁷ We asked the former Chair about criticisms of their appointment and their potential political connection. The former Chair told us that they had been clear at the outset that they were not a vaccines expert and that their experience was in “taking novel science and turning those into therapeutics”.¹⁸ They explained that, in essence, this meant demonstrating that treatments were effective and safe, ensuring they could be manufactured, and in getting the regulatory approvals needed so that they could be administered. They noted that there were other vaccine experts available, and others may have been better qualified, but that their “venture capital skillset and biotech mindset” had been what was needed for the Taskforce.¹⁹ We noted that in a pandemic it was not necessarily possible to undertake a full-recruitment process, but asked whether there should have been more discussion about, or others should have been involved in, the appointment of the Chair. The former Chair told us that they were not privy to what process took place. BEIS similarly told us that it was not privy to the process for this specific appointment and that, in non-emergency circumstances, it would still expect to undertake a normal recruitment process.²⁰

9. Our report on Government’s procurement and supply of personal protective equipment during the pandemic found that a failure to be transparent had opened up Government to accusations of poor value for money, conflicts of interest and preferential treatment of some suppliers, and risked undermining public trust in government procurement and the use of taxpayers’ money.²¹ BEIS recognised that the involvement of a range of different people being brought in to support government’s decisions created the potential for conflicts of interest. BEIS and the Taskforce share a register of conflicts of interest between their HR Department and Programme Management Office each week. By December 2020, 38 individuals within the Taskforce had registered at least one conflict of interest.²² We asked the Departments how they were ensuring that conflicts of interest were properly managed. Both the Department and BEIS explained that their approach

14 Qq 99, 112, C&AG’s Report, para 2, 1.1, 3.1–3.2

15 Qq 99–100, 116–117

16 Qq 101–102, C&AG’s Report para 3.1–3.5

17 Qq 109–110, C&AG’s Report, para 3.11

18 Qq 110–114, 118–121

19 Q 109

20 Qq 110–111, 117

21 Committee of Public Accounts, COVID-19: Government procurement and supply of personal protective equipment, HC 928, 10 February 2021

22 Q 106, C&AG’s Report, para 3.7

was the same as for any other area of their work and that they had standard procedures in place to deal with conflicts of interest.²³ BEIS told us that the majority of the conflicts of interests within the Taskforce were attributable to members of staff who had been brought in from the private sector, but that in most cases the potential conflicts of interest were small. It explained that it had needed to scale up its business-as-usual conflicts of interest system to deal with the quantity of people coming in, but that this was “not particularly because they have been more conflicted than usual, but because there have been more of them coming in from the private sector”.²⁴ We asked how Departments were ensuring that those who had left had not made any inappropriate personal or professional profit as a result of their work. BEIS confirmed that every member of staff was required to sign non-disclosure agreements and were clear about their responsibilities as part of working for Government.²⁵

Ensuring vaccine supply

10. We asked what premium the UK had paid for its access to the vaccines and their development at speed. BEIS asserted that the UK had not paid any premiums for access to the vaccines, as at the time the contracts were signed it was not possible to know what the final costs would be, but that it had secured access to the vaccines by negotiating “quickly and early”.²⁶ On the issue of the price of vaccines in future, it expected that its negotiating position would improve over time as more vaccines were approved and available.²⁷ Of those signed by December 2020, the UK’s contracts with pharmaceutical companies included: Astra Zeneca UK Limited and the University of Oxford for 100 million doses, signed in August 2020; Pfizer Inc and BioNTech SE for 40 million doses, signed in October 2020; and Moderna Inc for 7 million doses, signed in November 2020.²⁸ BEIS told us that, since the NAO report, it had signed contracts to provide access to a further 10 million doses to the vaccine produced by Moderna Inc.²⁹ We asked how Departments and the Taskforce had determined the doses they would need for each vaccine and why the UK had ordered such different quantities of the different vaccines. The former Chair of the Taskforce told us that this had been based on advice from the Joint Committee on Vaccination & Immunisation that it should look to vaccinate 30 million people in the high priority groups one to nine, equivalent to needing to secure access to 60 million doses if two doses were needed. They explained that the differences in the quantities ordered from manufacturers was a combination of the number of doses available and when those doses were expected.³⁰ DHSC policy is to vaccinate the entire population of the UK against Covid-19.

11. In response to our questions about whether the UK now had access to enough doses of vaccine or would need to go back to buy more from other suppliers, the former Chair of the Taskforce told us that the “we have more doses than we are likely to need, if they all work”.³¹ BEIS confirmed that was “absolutely confident” that supply would not be a constraint in achieving the mid-February target, even if take-up rates were higher than

23 Qq 103, 105–6

24 Q 106

25 Q 107

26 Q 29

27 Q 34

28 C&AG’s Report, para 2.2

29 Qq 32, 73

30 Q 30

31 Q 31

expected.³² BEIS explained that it was too early to say what would happen to any surplus doses as it depended on whether all those it had access to were approved for use, and what happened during the roll-out of the vaccines. It confirmed that it had, however, tried to ensure as much flexibility as possible in its contracts with pharmaceutical companies to allow it not to take-up vaccines or to consider alternative options.³³

12. On 11 January 2021, the Secretary of State of Health and Social Care stated that “the supply of the vaccine is currently the rate limiting step”.³⁴ NHSE&I recognised that ensuring everyone who wants a vaccination can have one by Autumn 2021 will depend on continuing vaccine supply.³⁵ Given this, we asked why Government did not yet have a timetable for when vaccines would be delivered. The former Chair of the Taskforce told us that, as part of procuring the vaccines, it had agreed a timetable for the expected supply of vaccines, but that this had taken place before the manufacturing of the vaccines had been fully scaled-up. BEIS confirmed that it was working daily with suppliers and had detailed schedules for the supply of vaccines until the end of February, and was “increasingly confident” about the schedules for March.³⁶

13. Manufacturing the vaccines is the responsibility of pharmaceutical companies. In order to ensure that vaccines can be provided quickly to the UK and reduce the risks to its supply of the vaccine, BEIS calculated that it needed to invest £519 million to provide manufacturing capacity for producing the vaccines within the UK. By 8 December 2020, it had committed £302 million to manufacturing projects, including: £127 million to the Cell and Gene Therapy Catapult Manufacturing Centre; £93 million to the Vaccine Manufacturing and innovation Centre; and £42 million to fill and finish facilities. BEIS told us it was confident that, if it needed to, the UK now had sufficient capacity, and a full contingency, to manufacture all the vaccine doses that it might need.³⁷

32 Qq 71–72

33 Q 32

34 [Health and Social Care Secretary’s statement on coronavirus \(COVID-19\)](#), 11 January 2021

35 Qq 5, 22

36 Qq 70–71

37 Qq 45–46, C&AG’s Report, para 18, 2.14–2.15

2 Part Two – Deploying the vaccines

14. Government plans to have offered a first vaccine dose to everyone in the top four priority groups identified by the Joint Committee on Vaccination and Immunisation by 15 February. This includes: all residents in a care home for older adults and their carers; all those 80 years of age and over and frontline health and social care workers; all those 75 years of age and over; and all those 70 years of age and over and clinically extremely vulnerable individuals; and is equivalent to around 12.2 million people.³⁸ In January 2021, the Government announced that it would likely take until spring to offer the first dose of the vaccine to the remaining priority groups, equivalent to around 27 million people in England. It planned to offer a vaccine to the remaining adult population by the autumn.³⁹

15. We asked NHSE&I whether the timetable for the roll-out of the vaccine was realistic, and how fast it could reach those groups on the priority list. NHSE&I told us that over the first three weeks of the programme, it had administered around 1.1 million doses across the country, and that the speed of vaccinations had tripled over the last week, with 1.2 million vaccinations, meaning that 2.3 million vaccinations had now been administered in England and 2.5 million across the UK.⁴⁰ As of [date] over [10] million had been delivered. We commended the progress that had been made to date, but noted that there was still a huge amount of work to do to meet the government's target. NHSE&I expected the number of vaccinations to further accelerate in the coming weeks as supply of the vaccines increased and confirmed it was on course to have offered a vaccine to everyone in the first four priority groups by 15 February as planned.⁴¹

16. NHSE&I is planning its deployment of vaccines in the face of high levels of uncertainty because information about the COVID-19 vaccines is still changing. It needs to keep its plans under review to ensure it can respond to the latest information about which vaccines have been approved, which groups in society need to be vaccinated, how many doses will be available, and when and how those vaccines will need to be deployed. The NAO found that it remained uncertain whether the vaccination programme would need to take place more regularly, for example becoming an annual programme.⁴² We asked Departments whether they now thought that an annual vaccination programme would be needed. BEIS confirmed that it was considering this, but that it was not an urgent or critical question at present as it had “plenty of doses to be getting on with, not only for this year, but likely for next year as well”.⁴³ It explained that while it had needed to work at speed for the current programme, it expected to be able to take time to “survey the field” and plan for any future annual vaccination programme.⁴⁴ In response to our questions about when these decisions would need to be made, BEIS told us “not for a while”.⁴⁵ The Department explained that plans for the vaccination programme in future will also depend on how the virus develops and any new variants, and it would respond as information became available.⁴⁶

38 Q 17–18, Department of Health and Social Care, [UK COVID-19 vaccines delivery plan](#), 13 January 2021

39 Qq 5, 19, Department of Health and Social Care, [UK COVID-19 vaccines delivery plan](#), 13 January 2021

40 Qq 3, 8, 18

41 Qq 3–4, 6, 16, 22

42 Q 37, C&AG's Report, para 5, 28, 4.13–14

43 Q 33

44 Qq 33, 36

45 Qq 35–36

46 Qq 37–38

17. Decisions about who will be vaccinated were taken by the Secretary of State for Health and Social Care, as is the case with all vaccination programmes, based on advice from the Joint Committee on Vaccination and Immunisation.⁴⁷ The Joint Committee identified nine priority groups for the first phase of vaccinations to maximise the effectiveness of the programme and prevent further deaths from COVID-19. These groups were predominantly based on age in light of evidence that this was the single greatest risk of mortality from COVID-19. When the groups were announced, the Joint Committee recommended that the second phase of the vaccination programme should focus on preventing further hospitalisation and acknowledged that vaccinating those at increased risk of exposure due to their occupation could also be a priority.⁴⁸ In its written evidence to us, the Nuffield Council on Bioethics told us that it would be important that Governments were transparent about their prioritisation strategies for delivering vaccines and good communication about the values, evidence and criteria behind those decisions would be key.⁴⁹ We also received written evidence from JKS Bioscience Limited, which told us that, as well as older people, the vaccine programme should prioritise: medical staff and care staff; school teachers and staff; University students, staff and researchers; and workers and consumers.⁵⁰

18. We asked what progress had been made in identifying who would be prioritised in the next phase of the vaccine programme and whether those in key services, for example education, transport and those working in supermarkets, would be given priority. NHSE&I told us that, while these were decisions for Ministers and the Joint Committee, it thought that there was a strong case for asking the Joint Committee to consider specific groups, particularly teacher and other key workers, once the first priority groups had been vaccinated.⁵¹ The Department explained that, to support those decisions, it would be important to know more about the extent to which the vaccines stop the transmission of the virus, as well as the extent they stop people getting sick and how long protection from the vaccines lasts.⁵²

Getting the vaccines to the right people at the right time

19. Each potential vaccine will require different plans for deploying it to the public because each vaccine has different characteristics. This includes the temperature vaccines need to be stored at, their shelf-life once open, and any preparatory work needed before they are administered.⁵³ The Pfizer Inc and BioNTech SE vaccine, for example, must be stored at minus 70°C. In comparison, the vaccine developed by the Astra-Zeneca Ltd—University of Oxford partnership can be stored at between 2°C and minus 8°C. The former Chair of the Taskforce confirmed that the Taskforce considered the logistics needed to administer a vaccine as part of determining which vaccines to buy, but that its overriding concern had been whether the vaccine itself would work.⁵⁴ PHE acknowledged that delivering the Pfizer vaccine was “the most tricky” but was confident that its previous experience

47 C&AG’s Report, para 1.

48 Department of Health and Social Care, [Joint Committee on Vaccination and Immunisation: Advice on priority groups for COVID-19 vaccination, 30 December 2020](#), updated 6 January 2021

49 PFV0004 – Written Evidence submitted by Ms Richella Logan on behalf of Hugh Whittall, Director of Nuffield Council on Bioethics,

50 PFV0001 – Written Evidence submitted by Karl Simpson, Director JKS Bioscience Limited

51 Q 7

52 Qq 9–10

53 C&AG’s Report para 2.2, 4.4–4.7

54 Q 65

of delivering vaccinations programmes meant it had the skills and expertise it needed to deal with each vaccine.⁵⁵ We asked about anecdotal reports of teething problems with the roll-out of the vaccines, including double vaccines appearing at GP practices, or people expecting one type of vaccine and receiving another. NHSE&I told us that it investigated any mistakes to work out what had happened and how to ensure they were not repeated. It emphasised, however, that 97.3% of the vaccine deliveries, and 98.15% of all deliveries related to the vaccine programme, had been on time and in full.⁵⁶

20. In September 2020, NHSE&I estimated that it could need up to 46,000 additional staff to deliver the COVID-19 vaccination programme, including 26,000 vaccinators and 20,000 administrative staff. It planned to fill these posts through a combination of existing primary care staff and targeted local recruitment campaigns.⁵⁷ At the time of our evidence session, the Department had recruited 80,000 people to deploy the vaccines.⁵⁸ NHSE&I told us that while the workforce needed for the programme had been “of real concern”, the response to its call for volunteers and clinical staff had been “incredibly successful – more so than we could ever have imagined”. Over 200,000 people expressed an interest in supporting the vaccine programme. Not all of those who volunteered will be deployed immediately, but NHSE&I told us that it was confident it had the staff it needed to scale-up the programme as planned.⁵⁹

Local distribution

21. The NHSE&I concluded that it was not possible to deliver both the COVID-19 and seasonal flu vaccinations solely through existing arrangements such as GP practices and community pharmacies. In response, it developed three new delivery models to take account of different groups and different regional needs. Each region must choose the delivery models that best suit local conditions.⁶⁰ We asked NHSE&I what oversight it had of local decision making about the programme and how it was taking into account the different proportions of priority groups in local areas.⁶¹ NHSE&I recognised that it would be unfair for one part of the country to run significantly ahead of others and that it was conscious of the trade-off between ensuring complete equity in the supply and availability of vaccines and in ensuring as many people were vaccinated as quickly as possible. It explained it was working to ensure that all Primary Care Networks (PCNs) were able to vaccinate those over 80 and care home residents. Where PCNs had been able to successfully vaccinate all those over 80 in their area, it had so far redistributed vaccines to those PCNs who had a larger group of people over 80 to vaccination and who still needed doses. It confirmed, however, that “as soon as we are at reasonable coverage”, it expected to be able to talk to the Chief Medical Officers about pushing out as many vaccines as possible.⁶²

22. We were concerned that this approach risked creating a ‘stop-start’ system where the logistics for vaccinations people were in place, but would be difficult to get up and running again if the roll-out was paused while other areas caught up. NHSE&I confirmed

55 Qq 63–65

56 Q 67

57 C&AG’s Report, para 4.13

58 Q 77–78, Department of Health and Social Care, [UK COVID-19 vaccines delivery plan](#), 13 January 2021

59 Qq 77–78, Department of Health and Social Care, [UK COVID-19 vaccines delivery plan](#), 13 January 2021

60 C&AG’s Report, para 26, 4.8–4.11

61 Qq 68, 81

62 Q 81

that it was bearing in mind the importance of having a smooth distribution in addition to vaccinating priority groups as soon as possible. It noted that the mix of delivery models, including mass vaccination centres and community pharmacies, would be essential in helping smooth the distribution of vaccines in local areas and meet the needs of the population in each area.⁶³ NHSE&I changed how it communicated with PCNs about what and how many vaccines would be delivered each week, including communicating directly with vaccine sites to ensure information was not delayed. It told us that, as of the end of the day, it would also have shared information with PCNs on the supply of vaccines available over the next two weeks rather than only the next week, so that PCNs could better plan ahead. It explained that it would contact individual PCNs if additional supply became available and would focus any additional supplies on PCNs with the largest populations of the priority groups being vaccinated to ensure that they had enough to vaccination patients in “roughly the right order” without holding up overall deployment.⁶⁴

23. In its written evidence to us, the Nuffield Council on Bioethics noted that COVID-19 had a disproportionate impact on groups who already had unmet health needs, such as poorer and BAME communities, those living in care and those with learning disabilities. It explained that it was important that plans for the allocation and distribution of the vaccine carefully considered these groups in order to avoid exacerbating existing inequalities.⁶⁵ We asked PHE how it was ensuring that communities, vulnerable groups, or those with specific needs such as people with learning disabilities, were not being left behind by the vaccine programme. PHE recognised that COVID-19 risked amplifying the impact of inequalities, particularly those with learning disabilities, and committed to writing to us about what specifically it was doing to support those affected.⁶⁶

63 Q 82

64 Qq 67–68

65 PFV0004 – Written Evidence submitted by Ms Richella Logan on behalf of Hugh Whittall, Director of Nuffield Council on Bioethics,

66 Q 89

3 Part Three – Public confidence and communication

Expectations for the vaccines programme

24. NHSE&I recognised that its goal of vaccinating the top four priority groups by mid-February was a huge task.⁶⁷ We noted that it would be essential for Departments to be clear in the language they used to describe progress with the vaccine programme to avoid over-promising and under-delivering. We asked what counted as a vaccine having been offered and how it was monitoring and reporting progress. NHSE&I explained that it could not force people to take the vaccine, so was monitoring progress on the basis of how many people had been offered a vaccine.⁶⁸ It planned the roll-out of the vaccine on the assumption that 75% of people who are offered the vaccine will take it.⁶⁹ We were concerned by the potential for confusion between expected take-up and figures currently in the public domain about the number of people who will be vaccinated. If, for example, 25% of each cohort choose not to take-up the offer of a vaccine, then the programme would not be able to meet the expected number of people being vaccinated.⁷⁰ NHSE&I told us that national data on the roll-out of the vaccine had been published each week and would now be published on a daily basis. It confirmed that it expected to publish localised data by region, and by local authority if possible, within the next 7–10 days.⁷¹ However, while government aims to have offered a vaccine to 12.2 million people by 15-February, its daily and weekly progress reports only include statistics on the number of “announced vaccinations” i.e. vaccinations that have been administered rather than how many have been offered.⁷²

25. When it was first rolled-out, the vaccine programme included a three-week break between people receiving their first and second doses. In December 2020, the Government announced that the second dose of the vaccine would be administered 12 weeks after the first dose.⁷³ We asked why this decision had been made and whether it would be reviewed in light of the current, or future, lockdowns. The Department explained that the decision was based on the advice of the Joint Committee on Vaccination and Immunisation and the Chief Medical Officers and “basic maths” that it was better to get a first dose to as many vulnerable people as possible and delay the second dose, than to give second doses to the same people. It emphasised that the second dose was still very important to vaccinating people against the virus, but the more the virus spread, the more important it was to maximise the number of people who had the first dose. It confirmed that its decision was not explicitly linked to the lockdown, and it would “keep all those things under constant review as the evidence develops”.⁷⁴

67 As of 10 February, in the UK, 12,646,486 people had received a first dose and 516,392 people had received a second dose, indicating that the government is on track to achieve this target. <https://coronavirus.data.gov.uk/details/vaccinations>

68 Q 6

69 Q 6, C&AG’s Report, para 4.2

70 Q 74

71 Qq 3, 20–23

72 NHS England – [Data on COVID-19 Vaccinations](#)

73 [Statement from the UK Chief Medical Officers on the prioritisation of the first doses of COVID-19 vaccines](#), 30 December 2020

74 Qq 51–52

Expected take-up of the vaccine

26. In 2019–20 the long-established seasonal flu vaccination programme had a take-up rate of 72% among those aged 65 years and older, and up to 45% for those aged 64 years or younger. NHSE&I explained that it was using the flu vaccine as an indicator for expected take-up of the COVID-19 vaccine programme as both targeted the same age group. In addition, the COVID-19 vaccine programme was being rolled-out at a time of increased concerns about the virus in the older population. NHSE&I recognised that, while a useful indicator, take-up rates of the flu vaccine would not determine take-up of the COVID-19 vaccines, but asserted that early signs of take-up among those aged 80 and above were very strong. It confirmed that its plans for the supply of vaccines meant the enough would be available should take-up rates be higher than expected.⁷⁵

27. PHE recognised that people trust their local GP, local faith groups and community groups so public health organisations and local government will have an important role to play to encourage people to take-up the vaccine. Flu vaccination programmes have also shown the importance of convenience and location to the take-up of vaccines, particularly within harder to reach communities.⁷⁶ We therefore asked about reports that people had received letters sending them to mass vaccinations which were not close to where they lived. The Department confirmed that while people had been invited to larger-scale vaccination centres, this was “simply an additional option that some people may choose to avail themselves of” and that those individuals would also receive an invitations from their local GP service to have the vaccine at a more convenient location if they would prefer.⁷⁷

Communication about the vaccine programme

28. The number of people who choose to have the vaccine will ultimately be determined by public trust in the vaccines.⁷⁸ Our previous reports have shown the importance of clear and consistent communication and that a lack of information during the pandemic, or repeatedly changing and updating guidance, can be confusing and frightening for those affected.⁷⁹ The Department of Health & Social Care is responsible for developing a communications plan and communicating with the public about the vaccination programme. It established a cross-Government communications team, including representatives from the Vaccine Taskforce and the Cabinet Office, to consider communication about the vaccine. The Department of Health & Social Care explained that communication about the COVID-19 vaccine programme was more difficult than with other vaccine programmes because the situation was evolving so rapidly. In June 2020, Public Health England emphasised the need for attitudinal research to inform the communications strategy, but this research was not complete in time for the first vaccinations. PHE confirmed that it still planned to undertake a range of attitudinal surveys, and was working with Newcastle University and the London School of Hygiene & Tropical Medicine as part of this as well as undertaking weekly polling through YouGov.⁸⁰

75 Qq 72, 92, C&AG’s Report para 24

76 Q 88

77 Q 12

78 C&AG’s Report, para 24, 4.3

79 Committee of Public Accounts, COVID-19: Government procurement and supply of personal protective equipment, HC 928, 10 February 2021

80 Qq 88, 124, C&AG’s Report, para 24, 4.3

29. Research commissioned by PHE showed that about two-thirds of the population were very likely to take-up the vaccine, around 10% were unlikely, and the rest were uncertain. For those who were uncertain or unlikely to have the vaccine, efficacy and safety were the key issues. We asked witnesses what were the key risks to public confidence in the COVID-19 vaccines. NHSE&I that these were very similar to other vaccine programmes that the NHS ran successfully each year, but that the scale of the programme and the newness of the supply chain were different. The Department of Health & Social Care recognised the need for clear messaging to enable the public to understand progress with the vaccine programme and be assured that the vaccines were being deployed safely and properly.⁸¹

30. We were concerned by reports of confusion among health professionals and the public about what to expect from the vaccine programme and when. We asked NHSE&I how it was ensuring clear lines of communication so that people had access to accurate information quickly and easily.⁸² NHSE&I explained that its messaging was first and foremost “you will be contacted”, in contrast to seasonal flu vaccinations where people could present themselves to their local pharmacist. We similarly asked NHSE&I whether it had a rebuttal unit to dispel any myths about the vaccine programme, or a Frequently Asked Questions section on its website to answer queries from the public. NHSE&I agreed that including FAQs about the vaccine programme on its website would be sensible and committed to introducing this immediately.⁸³

31. NHSE&I explained that it would give people “more than one channel and more than one chance” to come forward for a vaccine. It expected to have to go back to people who did not come forward after being contacted to understand why they had not responded and give them another opportunity to take-up the vaccine.⁸⁴ It similarly planned to use different ways to try to make sure that those who were vaccinated returned for their second dose, including pre-empting any issues by booking both appointments at the same time and putting in place procedures to identify and contact anyone who didn’t come to their second appointment.⁸⁵ We were alarmed by reports of an individual calling on a house, charging money and administering a fake vaccination and how NHSE&I would ensure that such instances were not repeated. NHSE&I recognised the need for “great vigilance” on this, but that it was ultimately a matter for the police and the Home Office.⁸⁶

81 Qq 87–88

82 Qq 81–86

83 Qq 79–80

84 Q 89

85 Q 59

86 Qq 11, 89

Formal minutes

Wednesday 10 February 2021

Virtual meeting

Members present:

Meg Hillier, in the Chair

Mr Gareth Bacon	Dame Cheryl Gillan
Olivia Blake	Peter Grant
Sir Geoffrey Clifton-Brown	Mr Richard Holden
Barry Gardiner	James Wild

Draft Report (*COVID-19: Planning for a vaccine Part 1*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 31 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Forty-third of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Thursday 11 February at 9:15am]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 11 January 2021

Sarah Munby, Permanent Secretary, Department for Business, Energy and Industrial Strategy; **Emily Lawson**, Chief Commercial Officer, NHS England and NHS Improvement; **Sir Chris Wormald**, Permanent Secretary, Department of Health and Social Care; **Sir Simon Stevens**, Chief Executive, NHS England; **Michael Brodie**, Chief Executive, Public Health England; **Nick Elliott**, Former Director General and SRO, Vaccine Taskforce, Department for Business, Energy and Industrial Strategy; **Kate Bingham**, Chair, Vaccine Taskforce, Department for Business, Energy and Industrial Strategy

[Q1-130](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

PFV numbers are generated by the evidence processing system and so may not be complete.

- 1 Karl Simpson ([PFV0001](#))
- 2 Health and Care Professions Council ([PFV0002](#))
- 3 Royal College of Nursing ([PFV0003](#))
- 4 Nuffield Council on Bioethics ([PFV0004](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2019–21

Number	Title	Reference
1st	Support for children with special educational needs and disabilities	HC 85
2nd	Defence Nuclear Infrastructure	HC 86
3rd	High Speed 2: Spring 2020 Update	HC 84
4th	EU Exit: Get ready for Brexit Campaign	HC 131
5th	University technical colleges	HC 87
6th	Excess votes 2018–19	HC 243
7th	Gambling regulation: problem gambling and protecting vulnerable people	HC 134
8th	NHS capital expenditure and financial management	HC 344
9th	Water supply and demand management	HC 378
10th	Defence capability and the Equipment Plan	HC 247
11th	Local authority investment in commercial property	HC 312
12th	Management of tax reliefs	HC 379
13th	Whole of Government Response to COVID-19	HC 404
14th	Readying the NHS and social care for the COVID-19 peak	HC 405
15th	Improving the prison estate	HC 244
16th	Progress in remediating dangerous cladding	HC 406
17th	Immigration enforcement	HC 407
18th	NHS nursing workforce	HC 408
19th	Restoration and renewal of the Palace of Westminster	HC 549
20th	Tackling the tax gap	HC 650
21st	Government support for UK exporters	HC 679
22nd	Digital transformation in the NHS	HC 680
23rd	Delivering carrier strike	HC 684
24th	Selecting towns for the Towns Fund	HC 651
25th	Asylum accommodation and support transformation programme	HC 683
26th	Department of Work and Pensions Accounts 2019–20	HC 681
27th	Covid-19: Supply of ventilators	HC 685

Number	Title	Reference
28th	The Nuclear Decommissioning Authority's management of the Magnox contract	HC 653
29th	Whitehall preparations for EU Exit	HC 682
30th	The production and distribution of cash	HC 654
31st	Starter Homes	HC 88
32nd	Specialist Skills in the civil service	HC 686
33rd	Covid-19: Bounce Back Loan Scheme	HC 687
34th	Covid-19: Support for jobs	HC 920
35th	Improving Broadband	HC 688
36th	HMRC performance 2019–20	HC 690
37th	Whole of Government Accounts 2018–19	HC 655
38th	Managing colleges' financial sustainability	HC 692
39th	Lessons from major projects and programmes	HC 694
40th	Achieving government's long-term environmental goals	HC 927
41st	COVID 19: the free school meals voucher scheme	HC 689
42nd	COVID-19: Government procurement and supply of Personal Protective Equipment	HC 928