

Monday, 3 March 2025

(10.30 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning. Today we begin the hearings into Module 5, procurement. During these hearings we shall be investigating a number of issues, including alleged profiteering, quality of the equipment supplied, and the High Priority Lane.

The Inquiry will investigate how the systems used by the four governments of the United Kingdom worked, and whether they can be improved for a future pandemic.

Our investigation includes analysis of some of the contracts to supplier equipment but does not require me to call individual suppliers. My focus will be on how the government responded to the suppliers' offers.

It is not my role, and indeed, I am forbidden by the Inquiries Act, to attribute civil or criminal liability to any individual or company. I am aware that there are ongoing investigations into some of the matters had will be touched on by this module, and in one case I have agreed that some evidence will be heard with special restrictions applying, to make sure I can hear the evidence without prejudicing any possible criminal investigation. The information that I receive will become public as soon as any criminal investigations are

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down in the following ways: PPE, about £14.9 billion; NHS Test and Trace, approximately £26 billion; and ventilators, approximately £700 million.

These sums were spent on the authority of dozens of ministers and many hundreds of officials on behalf of the public across the four nations. They were, in so doing, exercising powers to purchase vitally important healthcare equipment during the course of the emergency. It is the key decisions of these individuals and the contracts they entered into on behalf of the public during this time which form the subject of the scope of this module, and its resulting investigation.

To place this figure in context, the Inquiry in Module 1 found, as an estimate, that the total cost of government spending resulting from Covid-19 on all measures, including support for businesses, public services, individuals, health and social care, and operational expenditure, was in excess of £376 billion.

The expenditure on the procurement of PPE, lateral flow tests, and equipment for PCR testing and ventilators combined represents 11% of this sum, split 4%, 7%, and 0.2% respectively.

The investigation within this module has focused on the procurement of key healthcare equipment and supplies, particularly that of PPE, lateral flow tests,

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resolved.

Before I ask Mr Wald King's Counsel to outline the issues that we will be investigating, as usual, we shall play an impact film in which people describe their experience of the pandemic.

Given the nature of their accounts, people may find them distressing, and I recommend that those who do not wish to see the film, if they're following online, that they press pause now, or if they wish to, they leave the hearing room. The video lasts about 20 minutes. Please play the film.

[Impact film was played]

LADY HALLETT: I don't know if anyone wishes to return.

Yes.

Mr Wald.

Opening statement by LEAD COUNSEL TO THE INQUIRY for
MODULE 5

MR WALD: My Lady, the subject of this, the fifth module of the Inquiry, is the procurement and distribution of healthcare equipment and supplies during the Covid-19 pandemic. The total expenditure by the governments of the UK and devolved administrations on PPE, ventilators, and testing supplies, incurred during the period of focus for this Inquiry, that is 1 January 2020 to 28 June 2022, was approximately £41.2 billion, broken

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and equipment for PCR testing. Expenditure on those alone during the pandemic constitute 1.5% of the UK's 2023 gross domestic product.

Or to put it another way, in the year 2019 to 2020, SCCL, the NHS commercial entity for which NHS trusts and boards procure a significant amount of health and care equipment and supplies, procured around £146 million of PPE, which is 1% of the amount spent on PPE procurement in 2020 alone.

It should be noted that PPE was, before the pandemic, not a category of product that was needed in vast quantities.

On any view, these are very significant sums, and worthy of thorough investigation. This module will be investigating what happened, in order to better understand how money was spent during the pandemic, and to learn lessons as to how it might be more effectively spent if needs be in the future.

The level of spending on such healthcare equipment was not anticipated by anyone, including His Majesty's Treasury. To take the example of PPE alone, the Treasury's spending envelopes, that is the total amount of money it plans to spend over a set period of time, expanded 138-fold, from £100 million to £13.8 billion, as this graph shows.

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1 And I'd ask for Inquiry document INQ000474916 to be
2 displayed.

3 This was to respond to the buying which was led by
4 the Department of Health and Social Care.

5 One can see from the graph over the period of
6 100 days between the first purchase and last purchase of
7 PPE, between 22 March 2020 and 30 June 2020,
8 ever-increasing spending envelopes as one moves across
9 the graph. These sums, vast as they are, have
10 understandably been the subject of considerable public
11 interest and media attention.

12 One of the questions which has been, and continues
13 to be, posed is whether, during the course of the crisis
14 which faced the country, the public purse was exploited
15 for personal gain by those with close connections to
16 government and officials. There has been a substantial
17 amount of public discourse about whether there was
18 corruption, cronyism, and misuse of public money carried
19 out under cover of protecting frontline health and
20 social care workers, as well as the public, from
21 Covid-19 infection. The Inquiry has considered not only
22 referrals by those with connections to the then
23 governing Conservative Party, but also those made by
24 political parties including the Labour Party.

25 It is worth re-emphasising -- and, my Lady, this is
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1 course, cover those areas identified in its scope, as
2 depicted here.

3 And this, my Lady, as you will be well aware, is
4 a document that is available on the Inquiry website.
5 It's two pages long and it sets out the parameters of
6 Module 5.

7 There it is. Thank you.

8 A list of issues for Module 5 has been published and
9 is also available on the Inquiry website. Key topics or
10 themes deriving from that list, and to be addressed
11 across the UK and devolved administrations over the
12 course of the next four weeks, include the following:
13 procurement systems and their underlying rationales;
14 logistics and distribution, including any impediments
15 experience; skills, expertise and experience; emergency
16 trade and material strategy, regulation, inspection and
17 quality control; governance, transparency and
18 accountability; excess purchasing, waste and disposal;
19 and, finally, the importance of data in procurement
20 processes.

21 Module 5 will focus on the operation of the systems
22 and processes for the procurement of PPE, ventilators
23 and oxygen, lateral flow tests and PCR test kits. This
24 is because these are the particular items which the
25 Inquiry identified during its investigation as best

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1 a matter to which you have referred in your introductory
2 comments this morning -- an important point already made
3 at preliminary hearings in this module, namely that it
4 is not its function, or that of the Inquiry more
5 generally, to investigate any such alleged abuses and
6 make findings to as criminal and/or civil liability.
7 Indeed, my Lady has pointed out that you are prohibited
8 from making such findings by Section 2 of the Inquiries
9 Act of 2005.

10 Module 5 is therefore focused instead on the
11 processes or systematic features within the government's
12 of the four nations relating to procurement of key
13 healthcare equipment and supplies, rather than the
14 conduct of individual suppliers which could offer
15 limited, if any, useful evidence as to the operation of
16 those systems and how they held up to the significant
17 pressures brought about by the pandemic, and whether
18 there was an efficient, effective and fair system for
19 public procurement during that period.

20 The hearings for Module 5 will cover a broad range
21 of issues identified by the Inquiry throughout the
22 investigation. It will examine procurement across the
23 four nations, and identify differences in practice, and
24 any impact that those differences had on the purchase of
25 key healthcare equipment and supplies. It will, of

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1 highlighting the issues which need to be examined, as
2 set out in the scope of the module.

3 Taking these three in turn, PPE demonstrates the
4 approach to large-scale procurement of high-volume,
5 low-value items and the effect of an open source
6 approach.

7 Ventilators considers the procurement of highly
8 technical medical equipment and how government worked
9 alongside industry in this endeavour.

10 And lateral flow tests and PCR testing equipment
11 examines the interaction of commercial strategy with
12 broader policy decisions, the reliance on external
13 expertise, and the overall approach to spending
14 controls.

15 We touch on these later on in the issues which arise
16 out of them throughout the hearings. A few words now
17 about the Inquiry's investigation in Module 5.

18 Over the course of the next four weeks, we will
19 continue to examine how the institutions, ministers and
20 officials of the UK Government and devolved
21 administrations responded to the unfolding shortage of
22 PPE and the urgent need to procure ventilators and
23 testing equipment during the Covid-19 pandemic.

24 Key amongst the bigger questions we will be seeking
25 to answer is, of course, how the UK's procurement

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1 processes and plans might perform better if and when
2 faced with the next global health emergency. The
3 recommendations the Inquiry will make within this module
4 will seek to provide an answer to that central question.

5 My Lady, there is no Every Story Matters report for
6 Module 5. Our focus in this module is emphatically on
7 procurement itself and, in particular, how decisions on
8 what to buy, at what price and from whom inform a proper
9 understanding of why there were shortages of adequate
10 PPE faced by the health and social care staff.

11 In order to understand how the decisions made at
12 official or government or devolved nations level
13 impacted end users and others in the market trying to
14 buy PPE, the Inquiry engaged with local authorities and
15 NHS trusts and boards across the four nations in
16 relation to the scale of procurement for their
17 organisation before and during the pandemic,
18 difficulties in obtaining key healthcare equipment and
19 supplies, and details of any lessons learned and
20 exercises carried out.

21 A summary of the relevant information provided to
22 the Inquiry has been provided to Core Participants. A
23 number of NHS trusts and boards and local authorities
24 were asked to provide written evidence to the Inquiry
25 giving more details about their experiences of procuring

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1 followed by the arrival of items, 50%, and cost, 49%.

2 In order to assist you, my Lady, in understanding
3 the impact of these procurement decisions, you will hear
4 from the NHS Confederation, the Royal College of Nursing
5 and the Cambridge University Hospital NHS Trust. Of
6 course, my Lady has already heard other forms of
7 procurement-related impact evidence in Module 3 of this
8 Inquiry, including from a number of frontline workers.

9 To date, the Inquiry team for Module 5 has received
10 251 witness statements, obtained following requests made
11 formally under Rule 9 of the Inquiries Rules of 2006.
12 It has disclosed no fewer than 15,367 documents.
13 Following the process the M5 Inquiry team is satisfied
14 that it has obtained all of the evidence necessary to
15 fulfil its objectives under the module's scope.

16 Naturally, not all of this evidence can or will be
17 referred to at our hearings but it has all greatly
18 assisted in our work.

19 Where relevant to the particular issues examined in
20 this module, that body of evidence will continue to
21 inform it as we progress through the hearings and, of
22 course, your report, including any recommendations. And
23 all of the statements produced by witnesses appearing
24 within this module will be published in due course.

25 I now turn to address you, my Lady, briefly on the

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1 healthcare equipment and supplies during the pandemic.

2 In order to help frame the importance of this
3 module, the decisions that were taken, and the systems
4 and processes to the end user, some stark facts and
5 figures are offered here. 91% of NHS trusts and boards
6 in England and Wales who responded reported difficulties
7 in obtaining key healthcare equipment and supplies with
8 PPE, respiration and ventilator equipment and oxygen
9 cylinders, most commonly cited as the most difficult to
10 obtain.

11 They highlighted that, in some instances, prices
12 were raised by 64%, due to fierce international
13 competition for products. Goods, including continuous
14 positive airways pressure, or CPAP, and non-invasive
15 ventilation masks, were reported as often low quality,
16 defective, out of date, lacking certification paperwork
17 and, even in one case, counterfeit.

18 Overnight changes in national guidance reportedly
19 caused surges of demand for certain types of PPE when
20 mandated, resulting in some trusts and boards suddenly
21 rationing supplies and being unable to comply with
22 government policies on PPE use. They also had to
23 interpret guidance implementation based on stock levels.
24 In local authorities, the vast majority of respondents,
25 77% in fact, cited item availability as their key issue,

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1 ways in which Module 5 complements the work of other
2 modules. In seeking, through the evidence, to cover the
3 scope of this module, we've been mindful of the
4 relationship between it and others which you have been
5 and will be considering in the course of this Inquiry.

6 Module 5 naturally builds upon and dovetails with
7 the work of other modules. Nonetheless, it is
8 a detailed investigation in its own right which digs
9 deeper into the workings of government procurement
10 during the pandemic than elsewhere at this Inquiry, and
11 is uniquely placed to provide a better understanding of
12 how that experience might be improved.

13 Where Module 1 ended on the preparedness and
14 resilience of the UK, this module will pick up the topic
15 of the make-up of the PPE stockpile and the planned
16 approach to supplementing it in the event of an
17 emergency such as the Covid-19 pandemic. This is
18 because the state of that stockpile self-evidently
19 informed the immediate procurement need.

20 The Inquiry found in the report for Module 1 that it
21 was clear that PPE needed to be stockpiled in advance of
22 a pandemic in sufficient quantities, fit tested and
23 connected to an effective distribution network. This
24 module will examine the extent to which what is
25 reflected in that conclusion was put into practice, and

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1 will therefore address the following issues: the
2 condition of the PPE stockpile in January 2020; whether
3 the fact that the UK had prepared for a flu pandemic
4 proved to be a material factor in its failure adequately
5 to prepare for the demands of PPE which were placed upon
6 it from the Covid-19 pandemic; and the response of the
7 governments of the UK and devolved administrations to
8 any inadequacy once it had been discovered.

9 It will also consider the current condition of the
10 stockpile and how it could most effectively be
11 supplemented by emergency procurement in the future.

12 Module 3 looked at the experiences of the NHS
13 workforce with PPE shortages on the front line, and
14 Module 6 will turn in due course to look at the care
15 sector.

16 This module will consider the antecedent decisions
17 which resulted in frontline workers either lacking or
18 coming close to lacking adequate healthcare-related
19 equipment and supplies such as PPE they so urgently
20 needed during the pandemic.

21 This Inquiry has heard in detail in Module 3 about
22 what the infection prevention and control (IPC) guidance
23 in the UK recommended and what the World Health
24 Organisation recommended insofar as PPE for frontline
25 health care workers is concerned.

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1 Put simply, procurement is the process by which
2 governments or public bodies buy items or services over
3 a certain value. Professor Sanchez-Graells will help us
4 put some flesh on those bones and set the scene for the
5 rest of the module, but for now, in essence, when
6 governments or public bodies undertake procurement, they
7 must, to adopt the language of the government's guidance
8 on procurement policy, comply with relevant provisions
9 of law to ensure value for money, which is defined as:

10 "The best mix of quality and effectiveness for the
11 least outlay over the period of use for the goods or
12 services bought."

13 Failure to do so can result in successful legal
14 challenges against those public bodies responsible for
15 procurement decisions. For regular or non-emergency
16 procurement there are statutory time limits for each
17 stage of the process, as well as transparency
18 requirements and measures built into the process which
19 assist in ensuring competition between suppliers and,
20 ultimately, in providing fairness and value for money
21 for the taxpayer. It is a specialist area. The
22 procurement of PPE ventilators, lateral flow tests and
23 PCR tests is even more specialised. In emergencies, it
24 is, however, possible to make direct awards of
25 contracts. This process does not require competition

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1 This module will examine how that was fed into the
2 procurement systems and inform decisions on purchasing
3 and quality control.

4 Finally, whilst Module 7 will look at the
5 establishment and operation of NHS Test and Trace in its
6 entirety, this module will isolate and consider the
7 procurement of the necessary PCR and lateral flow
8 testing equipment itself.

9 I will address you, my Lady, in a moment, on what
10 this module has learned through its investigations so
11 far, and the evidence that you will hear over the next
12 four weeks.

13 That account is structured in broadly chronological
14 order, which it is hoped will provide a useful backdrop
15 against which to consider and understand the procurement
16 decisions which were taken within the relevant period so
17 far as this Inquiry is concerned.

18 There are a number of key dates which we expect will
19 aid the Inquiry in framing the evidence in this module.
20 We will come on to how each of them fits within the
21 broader picture of decision making throughout the
22 procurement. But before addressing those matters, it is
23 worth pausing to consider briefly what is meant by the
24 exercise which lies at the heart of this module, namely
25 procurement.

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1 between suppliers and is much faster than
2 business-as-usual procurement, albeit that transparency
3 obligations are retained by means of post-award
4 publication requirements.

5 Throughout the pandemic, this process was used
6 extensively, and in all categories of equipment procured
7 across all four nations of the UK.

8 Since the pandemic, there has been legislative
9 reform in this area. We have, of course, taken into
10 account the new Procurement Act of 2023, which came into
11 force just a few days ago, on 25 February last week.
12 The provisions of that Act may bear upon the
13 recommendations made by this Inquiry.

14 Turning now, my Lady, more specifically to PPE
15 procurement, the Pandemic Influenza Preparedness
16 Programme or PIPP stockpile was held, as its name
17 suggests, in readiness for an influenza pandemic. But
18 in truth, the stockpile contained the PPE it was
19 anticipated would be needed to protect patients and
20 staff from any airborne respiratory infection. The
21 types and volumes of PPE held in the PIPP stockpile were
22 based on the clinical recommendations from the New and
23 Emerging Respiratory Virus Threats Advisory Group, or
24 NERVTAG.

25 The stockpile was overseen by Public Health England

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1 and ultimately by the Department of Health and Social
2 Care. The regular supply of PPE to frontline staff was
3 itself the responsibility of individual employers.

4 For the NHS, this was either arranged directly with
5 private wholesalers or via SCCL. The devolved nature of
6 procurement and logistics meant that there was no
7 centralised or consolidated information on supply
8 resilience in the NHS for PPE at the point the pandemic
9 emerged, nor were there any joined-up arrangements
10 governing procurement and logistics in relation to adult
11 social care. In that sector, private wholesalers alone
12 were the main source of PPE, with responsibility falling
13 to individual care homes.

14 In early February 2020, Public Health England and
15 SCCL were initially confident that, together with the
16 PIPP stockpile, their procurement efforts placed the UK
17 in a strong position. To put it mildly, they proved to
18 be very wrong.

19 There were two essential problems: firstly, with the
20 stockpile itself; and, secondly, with the contracts SCCL
21 anticipated could be activated in the event of
22 an emergency to supplement the stockpile.

23 The stockpile. According to SCCL, data provided to
24 the Cabinet Office in January 2021, about
25 £112 million -- 112 million of the 439 million, ie more

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1 What caused this failure? As governments around the
2 world woke up to the scale of the unfolding crisis,
3 export controls and the compulsory requisitioning of PPE
4 by exporting nations commenced. Countries around the
5 world sought to prioritise and protect their own
6 citizens and began to escalate their buying efforts on
7 an enormous scale.

8 But there was a particular problem: many of the
9 world's manufacturing supply chain led back to one
10 country, China, and this was no different in the UK. As
11 the pandemic swept the globe, there was a near-perfect
12 storm. The realisation that PPE would be a crucial
13 commodity in responding to the pandemic provoked
14 a scramble by nations to acquire it in enormous volumes,
15 which itself drove an exponential rise in demand for PPE
16 around the world.

17 At the same time, lockdowns in key supplying
18 countries caused disruption to manufacturing and export
19 controls and border closures caused a freeze in
20 distribution. Supply chains for healthcare equipment
21 needed in the pandemic response, such as PPE, had almost
22 entirely broken down. As John Manners-Bell, the
23 Inquiry's expert in supply chain management, puts it in
24 his report: the UK was not alone in facing supply chain
25 dysfunction. At the root of the vulnerability was

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1 than a quarter, items in the PIPP stockpile, as of
2 31 January, were out of date. Testing was carried out
3 to extend the shelf life of many of these items and many
4 were subsequently deployed with new expiry dates assigned.

5 The contracts. On 27 January 2020, SCCL began to
6 engage with suppliers on what were known as the PIPP
7 just-in-time frameworks, which I'll refer to as JITs.
8 These were pre-arranged contracts to augment the supply
9 of PPE and other clinical consumables to prepare for
10 what, by then, seemed the inevitable arrival of the
11 first cases of the virus in the UK.

12 The first case of Covid-19 in England was not
13 confirmed until 31 January 2020. The first JIT order
14 for 6.8 million FFP3 respiratory masks were placed the
15 very same day. Subsequent orders for products on JIT
16 frameworks followed throughout early February. However,
17 over the course of the same month, it became clear that
18 the JIT contracts would fail.

19 The first of these did indeed fail on 28 February.
20 Within the space of nine days, SCCL went, on the
21 19 February, from having confidence in its ability to
22 supply the necessary PPE to there being, in essence,
23 a collapse of the supply chain into the UK and, with it,
24 a commensurate collapse of the confidence it had
25 previously held.

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1 a model which was dependent on offshore production and
2 sourcing from remote, low-cost markets dominated by
3 China. This level of dependence on a single
4 international market, with all the risks, was one of the
5 most important reasons for the market dysfunction which
6 resulted during the pandemic.

7 But this was only one part of the picture. Markets,
8 of course, are not only about supply but also about
9 demand. As global supply chains collapsed, the market
10 became mired in yet more chaos caused by failures on the
11 demand side. Erratic buying behaviour, caused by
12 an inability of procurement professionals in the UK and
13 globally to accurately forecast demand, meant that large
14 orders were placed by those desperate either to prevent
15 shortages or to replenish ever-diminishing stocks. They
16 did not, however, have access to the adequate
17 information, whether at the national or international
18 level.

19 This resulted in the so-called 'bull whip' effect,
20 which we will examine in this module, where even small
21 variances in order quantities by parties results in much
22 larger orders upstream and thus excessive levels of
23 inventory being held to meet demand.

24 The sum effect of all of this was nothing short of
25 a market which had become fundamentally dysfunctional.

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1 So it was that, within the first few months of 2020,
2 PPE went from being a product that was in relatively low
3 demand, inexpensive, and bought and sold in an open
4 market, to one in which it had quite suddenly become
5 very valuable, costly and sought-after but traded in
6 extreme market conditions.

7 In this turbulent market, the price of PPE rose
8 rapidly. As compared with prices in the final quarter
9 of 2019, in June 2020 the price of FFP2 respirators had
10 risen by 411%; the price of gowns by 295%; the price of
11 gloves by 288%; and the price of aprons by 172%.

12 Within this dysfunctional market, existing suppliers
13 to the UK and devolved administrations ran out of PPE
14 and existing manufacturers of PPE ran out of the raw
15 materials needed to make it. By 27 February 2020, the
16 WHO acknowledged the acute global shortage of PPE. In
17 the first two months of 2020, international exports of
18 PPE from China were down between 13% and 16%, compared
19 with 2019, despite the increase in demand, due to
20 pandemic preparations.

21 In March 2020, SCCL received orders from trusts for
22 over 400 million items of PPE at a cost of approximately
23 £50 million.

24 This compared to an average month in 2019 when
25 comparable figures were 200 million-items at a cost of

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1 deliver the requiring level of PPE. In this chaotic
2 market a new strategy was urgently required.

3 The Cabinet Office and DHSC stepped in. A radical
4 new approach was taken to procurement, not only to PPE,
5 but also to ventilators and testing equipment, but first
6 staying with PPE.

7 A Parallel Supply Chain was established to procure
8 transport to the UK and distribute PPE and supplement
9 the existing infrastructure. A PPE Cell was established
10 by the DHSC to manage the effort.

11 The structure and staffing of the PPE Cell evolved
12 over time. The initial leadership team was formed of
13 Emily Lawson, the Chief Commercial Officer for NHSE;
14 Major General Phillip Prosser, seconded from the army's
15 101 Logistic Brigade; and Andy Wood, seconded from the
16 Cabinet Office Complex Transactions Team. You will hear
17 evidence from all three of these individuals during the
18 course of M5's hearings.

19 The PPE Cell brought together staff from the DHSC,
20 NHS England, commercial experts from across government,
21 and members of the armed forces.

22 On 22 March 2020, some three weeks after the failure
23 of the SCCL contracts, DHSC entered into its first
24 contract. On 10 April 2020, the PPE plan was published.

25 The Parallel Supply Chain was organised into four

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1 approximately £5 million.

2 Demand for PPE was projected to rise even higher as
3 the number of patients with Covid-19 increased. SCCL
4 had in place arrangements for the distribution of the
5 stockpile and for procurement of PPE but those
6 arrangements all but collapsed under the strain. It was
7 simply unable to cope. The Inquiry will examine the
8 underlying causes of this failure and ask whether
9 anything could have been done to anticipate this and
10 prevent it from occurring.

11 It is clear that the Government was left in
12 a quandary as to how it was going to acquire the
13 critical PPE to send health and social care staff
14 working on the front line of the pandemic. For
15 countries such as the UK, which did not have a domestic
16 manufacturing base to produce such healthcare equipment
17 as PPE, it is also clear that there was no choice but to
18 buy it, to buy it quickly and to import it from
19 overseas.

20 We now turn to the creation of the PPE Cell and
21 Parallel Supply Chain.

22 As, ultimately, the contracts which this country
23 sought to rely upon failed to deliver the required PPE
24 to the UK, new contracts were formed between SCCL and
25 private wholesalers, but these too were unable to

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1 teams. First, SCCL or existing suppliers. These
2 continued efforts to procure from suppliers on its
3 existing framework agreements. Jin Sahota was the chief
4 operating officer of SCCL at the time.

5 Second, the China Buy team. This was based in what
6 was then the Foreign and Commonwealth Office. It worked
7 with the British Embassy in Beijing to procure PPE
8 directly from, globally the principal country of supply,
9 China.

10 Third, the UK Make team. This was based in the
11 Department for Business, Energy and Industrial Strategy.
12 It sought to establish the domestic manufacture of PPE.
13 The UK Make team was initially let by contractors from
14 Deloitte Touche Tohmatsu Limited, and subsequently by
15 Lord Deighton and then Gil Steyaert.

16 The New Opportunities team, fourth and finally, was
17 based in the Cabinet Office. It considered offers from
18 other sources, most notably suppliers which did not
19 necessarily have a history of supplying PPE and often
20 acted as intermediaries between the UK Government and
21 manufacturers. This team was led by Darren Blackburn.

22 You will hear, my Lady, from Darren Blackburn later
23 this week and from Lord Deighton in the week of
24 17 March.

25 The Inquiry will examine the various differing

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1 approaches of these teams to procurement. We will
2 consider whether there was a coherent strategic approach
3 to the procurement effort, and in particular, whether
4 these four streams could effectively coordinate with and
5 complement each other. What were the advantages and
6 disadvantages of each approach? Were there issues in
7 the Parallel Supply Chain identified and remedied in
8 good time? And more generally, whether there are
9 relevant lessons to be learned in the event of a future
10 pandemic.

11 It is no understatement to say that, in common with
12 many of those involved with the response to the
13 pandemic, the stress placed upon individuals involved in
14 the procurement effort was immense. They were the ones
15 working behind the scenes, often around the clock, to
16 buy and transport to the front line vital PPE,
17 ventilators and testing equipment.

18 The Inquiry is acutely conscious of the pressures
19 under which many individuals were placed, but it would
20 not be right or fair to those individuals simply and
21 blithely to accept that, because of those pressures, all
22 that could have been done was done, without scrutinising
23 and seeking to understand the key decisions that were
24 taken and what could be done better in the future in
25 similar circumstances, and that, amongst other matters,

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1 You will hear evidence that those involved in
2 procurement were bombarded with information at every
3 stage of a potential contract's journey, relying on
4 cumbersome and disjointed information technology systems
5 and excessively bureaucratic processes, and under
6 extreme time pressure to make critical decisions about
7 contracts worth many millions of pounds.

8 What was the answer to this data overload? Should
9 there have been available to those in the PPE Cell
10 a more elegant solution than the use of emails and
11 telephone calls for communication, and the laborious
12 completion of individual forms and Excel spreadsheets?
13 Should there be available in the future a system which
14 is more focused on live or updatable data, and the use
15 of developments in technology than the one which DHSC
16 deployed?

17 The Inquiry will hear evidence that the market
18 required the DHSC to accept higher prices, greater risk
19 in contracts, and to accept that some assurance of the
20 product would need to occur after receipt of goods, in
21 order to secure sufficient PPE in time. In a global
22 scramble to procure it, the choice was to accept this or
23 simply not to buy at all.

24 The Inquiry will hear that, faced with this choice,
25 it prioritised securing sufficient PPE to meet health

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1 is what this module will seek to do.

2 A few words now about the PPE cell's eight-stage
3 end-to-end process. The PPE Cell that the DHSC
4 established was divided up into eight teams, each of
5 which specialised in a particular aspect of the
6 procurement process. These are: initial data
7 collection; identifying viable opportunities and
8 triaging; validation of opportunities; commercial due
9 diligence; confirmation and technical review; closed
10 teams, conditions and pricing; complete approval and
11 documentation; and send to DHSC for approval.

12 The DHSC's Parallel Supply Chain streams, China Buy,
13 UK Make, New Opportunities, each fed into this
14 eight-stage process. The approach taken by the PPE Cell
15 is described by Jonathan Marron, the Director General of
16 Primary Care and Prevention at the DHSC and PPE Cell
17 lead, from whom the Inquiry will hear as "stepwise".
18 You will hear from Mr Marron later this week.

19 What this meant in practice is that offers were
20 progressed through series of checks, including technical
21 assurance of the product being offered and due diligence
22 of the PPE supplier and/or manufacturer, where an offer
23 was considered suitable to be progressed, the final
24 decision was taken by the Department's accounting
25 officer or an official with delegated authority.

26

1 and social care needs. As the Inquiry has heard in
2 Module 3, from Sir Christopher Wormald, then the DHSC
3 Permanent Secretary, bluntly, "I would much rather be
4 answering questions about why we ended up with too much
5 PPE than other questions", but the instruction to buy at
6 all costs must have limits. What are they?

7 In all the circumstances, where vast sums of public
8 money were at risk, then, what were the safeguards on
9 ensuring that the system was governed by fairness,
10 transparency and value for money, to name but a few
11 important guiding principles?

12 The PPE call to arms. On 10 April 2020, the
13 Secretary of State for Health and Social Care, Matt
14 Hancock, issued, by way of public announcement, a call
15 to arms. Businesses which could supply PPE to the UK
16 Government were invited to come forward. Following the
17 call to arms, approximately 24,000 offers across 50,000
18 categories of PPE were made from over 15,000 suppliers.

19 The Inquiry will hear evidence as to the effect of
20 this call to arms on the whole procurement system. It
21 will consider the advice and strategy which underpinned
22 the policy and whether the system was prepared for the
23 avalanche of offers which followed that call. It will
24 also explore how it adapted and responded, and what
25 kinds of suppliers came forward, more particularly

28

1 whether they were intermediaries or manufacturers, what
2 benefits, if any, there were to the involvement of
3 intermediaries in supply chains, and whether they
4 complemented or competed with other lanes of
5 procurement, in particular China Buy.

6 The evidence of Sir Gareth Rhys Williams -- until
7 very recently, and during the pandemic, the Government's
8 Chief Commercial Officer -- is that by 7 April 2020,
9 notably three days before the Secretary of State's call
10 to arms, there had been over 3,000 offers of support:
11 2,946 from suppliers and 82 from manufacturers.
12 A backlog of offers for initial review and then
13 technical assurance review grew because, at peak, 400 to
14 500 new offers were being received on the Government
15 portal every day.

16 The vast majority of suppliers offering PPE were
17 assessed as unsuitable and yet triaging these offers
18 took considerable resources from an already stretched
19 team.

20 Were these resources better deployed elsewhere?

21 Related issues which fall to be considered include:
22 whether the UK's international procurement response was
23 effective; how this response complemented other aspects
24 of the UK's procurement drives, such as the domestic
25 manufacturing effort; whether the UK organised its

29

1 been made on merit, even if they had not been processed
2 through the VIP Lane, and, in another case, to have
3 breached its obligation to publish contract award
4 notices within 30 days of signing the subject contract.

5 The Inquiry's analysis will, however, be wider and
6 deeper than the Limited VIP Lane cases which have so far
7 found their way to the courts.

8 The Inquiry sought evidence from those noted on the
9 gov.uk website as having been involved in the High
10 Priority Lane. In this part of the investigation alone,
11 the Inquiry has received 36 witness statements from
12 referrers into the VIP Lane, and thousands of pages of
13 evidence have been considered by the Inquiry and, where
14 relevant, disclosed to Core Participants.

15 It is clear from evidence obtained by the Inquiry
16 that potential contractors escalated matters to their
17 MPs or to other high-profile contacts whom they
18 considered had influence. These, in turn, sought to
19 raise these matters and get government attention for the
20 suppliers who had contacted them.

21 We will explore whether the management of
22 expectations of such VIP referrers was a necessary and
23 reasonable use of Limited resources, whether the
24 shepherding and acceleration of offers received via the
25 HPL, the High Priority Lane, conferred an advantage on

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1 presumed efforts adequately to ensure that controls on
2 spending and quality were applied; and whether it
3 adapted rapidly enough to take into account changes in
4 policy guidance, regulation, and the building up of
5 inventory within the system struck an appropriate
6 balance between speed of procurement and the risk of
7 acquiring substandard kit, and benefited from
8 an efficient and robust system of regulation and
9 inspection.

10 My Lady, I now turn to the controversial subject of
11 the so-called VIP Lane.

12 There are few subjects which the Inquiry will be
13 examining which have received the attention of the VIP
14 or High Priority Lane. It is here that very public
15 allegations have been made of contracts being awarded to
16 friends of those in high places, of outright corruption,
17 of fraud, and of other forms of criminal conduct.

18 The evidence received by the Inquiry is that the VIP
19 Lane was established as a result of a purportedly
20 innocent need to assure ministers and others that offers
21 they had passed on to the PPE Cell were being followed
22 up. It has, of course, already been ruled to be
23 unlawful by the High Court, as it breached principles of
24 equal treatment, albeit that the contract awards under
25 scrutiny in that case were found still likely to have

30

1 those making such offers, when compared to those
2 received from outside the HPL, and whether disclosure of
3 VIP identities seeped into the decision-making process
4 itself.

5 Certainly, there were complaints from those who did
6 not receive responses as quickly as hoped for, threats
7 to go to the press or to Select Committees were made in
8 order to embarrass the Government into giving special
9 treatment. Some complaints were public, some were
10 reported in the media, and some complaints were
11 amplified on social media by opposition politicians. It
12 is currently maintained by both DHSC and the Cabinet
13 Office in their evidence to the Inquiry that the VIP
14 Lane was nothing more than a triage team. There was no
15 separate VIP stream for offers, that due diligence and
16 technical compliance checks were carried out in the same
17 way, regardless of the provenance of the offer, and that
18 there was no favouritism as a result of entry into the
19 VIP Lane.

20 This is not reflected in some of the contemporaneous
21 evidence and will be examined in the coming weeks.

22 It is clear that the likelihood of a contract award
23 was significantly higher if an offer had come through
24 the VIP Lane.

25 The Government Internal Audit Agency, or GIAA, found

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1 that approximately 10% of the companies who went through
2 the High Priority Lane were awarded contracts, compared
3 to approximately 1% of non-High Priority Lane companies.

4 The evidence of Sir Gareth Rhys Williams confirms
5 the disparity in success rates within and outside the
6 HPL, but even this figure failed to tell the full story,
7 since a number of suppliers secured numerous procurement
8 contracts. The Inquiry's own investigation, based on
9 the data provided to it by DHSC, has revealed that,
10 although HPL offers made up only 1.8% of those received,
11 they constituted 30.7% of all contracts awarded to
12 suppliers, and that, by marked contrast, only 1.1% of
13 offers received outside the HPL managed to do so.

14 In other words, the advantage to being in the HPL
15 was 17-fold, rather than the tenfold cited a moment ago.

16 This disparity is illustrated and summarised by two
17 graphics, which I'd ask to be put up on screen now, the
18 first is Inquiry document INQ000474992, and the second
19 is Inquiry document INQ000474993. What these
20 side-by-side graphics show is the significant advantage
21 in terms of success rate of being within the High
22 Priority Lane, with an absolute number of offers at 430,
23 115 of those offers being successful, so a 30.7% strike
24 rate on high priority offers made.

25 By contrast, if we look at the non-High Priority
33

1 operation of the PPE Cell and VIP Lane is represented in
2 a particular chart in the form of a funnelled diagram --
3 it's INQ000497031 -- which summarises the -- if one
4 looks at the top half in blue, non-HPL offers funnel
5 down quicker, essentially, than High Priority Lane
6 offers. And one can see from the list at the side, the
7 reasons for dismissal of offers.

8 But there's a much quicker narrowing down of offers
9 outside of the HPL than inside it.

10 This chart serves to illustrate at a high level
11 the scale of the efforts to triage and then refine the
12 very many offers which were received, and also, as
13 I say, the relative prospects at each stage of that
14 sifting process.

15 Thank you very much.

16 I turn now to thematic reviews of contracts and also
17 the closed hearing date to which, my Lady, you have
18 referred in your introductory remarks.

19 The Inquiry sought detailed evidence from DHSC in
20 relation to each contract awarded for PPE, including for
21 such critical items as masks, gowns, and eye protection.
22 The DHSC contracts schedule sets out in relation to each
23 contract the route of each one, UK Make, China Buy or
24 New Buy, the price paid, whether the contract was met
25 and if not, the reasons why not.

35

1 Lane offers, 23,570 were made, and that figure
2 constitutes 98.2% of the total made, with the success
3 rate, if we move over to the other graphic, being
4 a figure of 259 in absolute terms ...

5 Thank you.

6 The Inquiry's analysis of the VIP Lane, as with the
7 whole PPE Cell, will be driven by the evidence. We will
8 explore the pros and cons of the VIP Lane, the reasons
9 for the preponderance of those with connections to the
10 then-governing Conservative Party featuring in the VIP
11 Lane, and whether higher prices were paid for VIP
12 contracts.

13 My Lady, I don't know if that's a convenient moment
14 to pause?

15 **LADY HALLETT:** Certainly it is. I shall return at midday.

16 (11.45 am)

17 (A short break)

18 (12.00 pm)

19 **LADY HALLETT:** Mr Wald.

20 **MR WALD:** Thank you, my Lady. Before the short pause we
21 were looking at the Inquiry's analysis of the relative
22 prospects of success in securing a contract inside and
23 outside of the High Priority Lane.

24 I now turn to an aspect of the Cabinet Office's
25 analysis. The Cabinet Office's analysis of the

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1 The schedule essentially provides a detailed
2 analysis of the areas of scope of Module 5. It is
3 a significant piece of evidence and has assisted the
4 Inquiry in obtaining a detailed impression of PPE
5 procurement during the pandemic.

6 We have selected a number of examples of procurement
7 offers, including from the High Priority Lane, designed
8 to examine how the system stood up to the experience of
9 particular referrals and to illustrate how certain
10 themes played out within the procurement process.

11 Because those examples include referrals into the
12 HPL of a company, PPE Medpro, which is currently the
13 subject of criminal investigation, evidence relating to
14 that case will be heard in a closed hearing.

15 This follows a decision you made, my Lady, to grant
16 a restriction order on 25 January this year, having
17 balanced the competing public interests in that evidence
18 being heard publicly, and those in avoiding prejudice to
19 any future criminal proceedings.

20 And my Lady, as you made very clear in this
21 morning's remarks, but is worth perhaps re-emphasising,
22 according to the terms of that order, both Core
23 Participants and a number of accredited journalists will
24 have access to the single day of closed hearings, and
25 once any criminal process has run its course, no matter

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1 its ultimate outcome, the recording, transcripts and
2 evidence adduced in the closed hearings, together with
3 aspects of your reports which may touch on sensitive
4 issues within the meaning of the restriction order, will
5 be made public.

6 Now, my Lady, data, a topic which has featured in
7 previous modules and will no doubt continue to feature
8 in future ones, is that of data management and how it
9 might have been handled to better effect during the
10 pandemic.

11 In some respects, within the PPE Cell there may have
12 been too much information for individual officials to
13 properly absorb, consider and analyse. This information
14 and documentation overload will be one of the subjects
15 the Inquiry considers with respect of the efficiency of
16 the PPE Cell.

17 In others, however, there was a dearth of data from
18 which those involved in procurement could make informed
19 decisions. PPE procurement was based on modelled demand
20 for PPE but there was no experience of pandemic demand
21 to draw upon. DHSC had no access to data on the actual
22 use or so-called "burn rate" of PPE. Nor did it have
23 information on the inventories of PPE held in frontline
24 organisations. The Department only began to access DHSC
25 hospital inventory information from mid-May of 2020.

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1 place significant numbers of patients at risk. The NHS
2 counted up to 8,000 ventilators in operation across
3 the UK, but there were fears that hospitals would run
4 out of sufficient ventilator capacity within a matter of
5 weeks.

6 In February and March, estimates of need varied
7 between 59,000, 90,000, and 138,000 ventilator beds.
8 But the NHS supply chain lacked the resources to respond
9 adequately to this increased demand in the context of
10 a globally disrupted market, and so the government
11 strategy was to rapidly increase UK ventilation capacity
12 by buying as many ventilators as possible from both UK
13 and global suppliers.

14 In the early stages of the pandemic there was huge
15 international demand for ventilators and the parts used
16 to build them, greatly outstripping supply.

17 According to the Department for International Trade:
18 "Speculators, opportunistic intermediaries and
19 individuals had piled in, trading up prices
20 exponentially. Some of the units we looked at changed
21 ownership over five times in the past two weeks. The
22 prices quoted were on average triple the usual retail
23 price and at the peak of the market, many times over.
24 We had entered a ventilator procurement 'Wild West'."

25 At the end of March 2020, even credible offers of

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1 The situation in the care sector, according to the then
2 care minister, Helen Whately, was even worse. She says
3 in her evidence that there was a stark lack of data to
4 inform the pandemic response in care homes.

5 This module will explore, in relation to the
6 PPE Cell, whether there was in practice a database
7 system which enabled objective criteria and objective
8 criteria alone to be the driver of decisions to progress
9 and award contracts.

10 Moving on to ventilators. Ventilators are very
11 specialised items of medical equipment. Their design is
12 highly regulated for good reason. Their purpose is to
13 help patients to breathe and receive oxygen when they
14 are too unwell to do so themselves. Safety issues in
15 the context of ventilators can have catastrophic
16 consequences, and they are often part of a wider set of
17 breathing apparatus, connections to oxygen supplies and
18 beds in hospitals which require specialist staff trained
19 in operating particular models.

20 Immediately before the pandemic, the UK had limited
21 understanding about the number of ventilators that were
22 available. In the early pandemic of March 2020, as the
23 UK witnessed distressing scenes in Italy, it appeared we
24 were facing an imminent and dire shortage of
25 ventilators, which, if not quickly addressed, would

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1 ventilators from overseas were being made at very high
2 prices, with unit price sometimes doubling within the
3 space of a single day.

4 By 30 March 2020, DHSC anticipated a shortfall of
5 8,000 ventilators for April of that year, leading the
6 Department to conclude that the procurement of these
7 ventilators was necessary, despite the price being two
8 to three times above the average price range typical
9 outside of the pandemic.

10 On 3 March 2020 the Covid-19 Oxygen, Ventilation,
11 Medical Devices and Clinical Consumables Programme was
12 jointly established and funded by DHSC and NHSI to
13 enable NHS organisations to meet demand for oxygen
14 ventilators and consumables during surges of Covid-19.

15 On 13 March a ventilator target of 30,000 was set
16 for delivery by the end of June 2020. As it was clear
17 that it would not be possible to procure enough
18 ventilators for 30,000 beds, however, on 16 March 2020
19 the Prime Minister announced a call to arms to British
20 industry and organisations to help the UK step up
21 production of vital medical equipment, asking
22 manufacturers to offer their skills and expertise as
23 well as manufacturing the components for ventilators and
24 related equipment themselves.

25 This manufacturing drive came to be known as the

40

1 Ventilator Challenge and had two strands: one focusing
2 on offers from established suppliers, and the other
3 focusing on new suppliers of ventilators for England,
4 Scotland, Wales and Northern Ireland, and for overseas
5 territories. DHSC was responsible for managing the
6 offers from established ventilator suppliers whilst the
7 Cabinet Office took responsibility for managing new
8 suppliers, with the aim of making 30,000 ventilators in
9 just eight weeks.

10 The Department for Business, Energy and Industrial
11 Strategy managed a triage process to narrow down offers
12 received to those that were most credible and to
13 ascertain which offers of equipment made were credible.

14 Potential suppliers through the Ventilator Challenge
15 presented their ventilators to a group of clinicians and
16 staff from MHRA, the Cabinet Office and PA Consulting,
17 which in turn made recommendations about whether to
18 select certain ventilators for use in the NHS.

19 The ventilator parts market faced the same type of
20 global competition and disruption as PPE products,
21 complicated by the fact that the UK designs shortlisted
22 in the Ventilator Challenge were often competing for the
23 same components.

24 Transport management and provision was sometimes
25 undertaken on an *ad hoc* basis in response to events

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1 probe whether the government achieved the most robust
2 procurement possible under the timescales required,
3 whether its decision to directly award contracts in the
4 Ventilator Challenge exceeded the limits for extremely
5 urgent procurement, and whether some alternative course
6 might have been preferable.

7 I move now to NHS Test and Trace.

8 NHS Test and Trace began as a taskforce reporting to
9 the Prime Minister. It was formally established as an
10 entity in its own right on 28 May 2020 under the
11 leadership of Baroness Dido Harding, with responsibility
12 for leading a mass scale national testing and tracing
13 service for Covid-19. NHS Test and Trace would
14 subsequently, in 2021, be absorbed into what would
15 become the UK Health Security Agency.

16 In March 2020, only NHS pathology laboratories,
17 a few research sites and public health laboratories in
18 the UK had the ability to test for Covid-19. Total
19 testing capacity, using what was then considered to be
20 the gold standard for testing, PCR, was estimated in
21 practice to be just 3,000 a day. It was deemed this
22 needed to increase at scale and speed to 100,000 per day
23 by the end of April 2020, and 200,000 a day by the end
24 of May 2020 and beyond.

25 A call to industry was made on 2 April 2020 by the

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1 rather than in a planned manner.

2 Changing understanding of Covid-19 led to evolving
3 specifications for the numbers and type of ventilators
4 required. The peak requirement for ventilators was only
5 13,000 and the original target was reduced in April to
6 18,000, leaving a surfeit of parts which had already
7 been procured. In fact, demand in England for
8 mechanical ventilators peaked at just under
9 4,000 ventilators, for Covid and non-Covid patients,
10 between 12 and 18 April 2020.

11 At the time of the process, three of the
12 twelve candidates' designs were approved by the MHRA for
13 manufacture. The Cabinet Office also supported the
14 scaling up of production of the two already approved
15 devices. Many of the other additional ventilators which
16 were sourced came from China and, as with PPE, in some
17 cases there were quality control issues leading to the
18 rejection of ventilators which were considered unsafe.

19 Ultimately, however, the UK ended up with more
20 ventilators than were needed during the peak of the
21 pandemic.

22 By 30 May 2022, the UK had stockpiled
23 30,000 ventilators, over half of which had been produced
24 by the Ventilator Challenge.

25 So far as ventilators are concerned, this model will

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1 Secretary of State for Health and Social Care. By the
2 end of October 2020, PCR testing capacity exceeded
3 500,000 tests a day, and by the end of 2020, capacity
4 existed to undertake 750,000 tests a day.

5 When, in summer 2020, lateral flow testing became
6 available, the PCR testing effort was supplemented by
7 this alternative testing technology. By May 2021,
8 655 million lateral flow tests had been distributed.

9 To put NHS Test and Trace in perspective, the
10 evidence received by the Inquiry suggests that to
11 deliver the testing and contact tracing services
12 required to respond to the Covid pandemic, NHS Test and
13 Trace needed to establish a distribution network akin to
14 the scale of a major commercial enterprise. In
15 five months, NHS Test and Trace expanded testing
16 capacity from 921,958 PCR tests in the month of May 2020
17 to 7,415,253 processed in the month December 2020.

18 With this rapid expansion in testing capacity came
19 a concurrent increase in expenditure and apparently
20 a relaxation of spending controls at the centre of
21 government.

22 The amount spent on testing by 28 June 2022
23 eventually reached approximately £26 billion. This was
24 made up of just over £12 billion on PCR tests and just
25 short of 14 billion on lateral flow tests.

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1 It is not the place of this module to examine the
2 overall approach to testing, which is of course a matter
3 for Module 7, yet to come. Instead, the issues to be
4 examined in this module will include the challenges in
5 procuring complex specialist medical equipment such as
6 lateral flow tests and PCRs, the role of domestic
7 industry, the reliance placed on external expertise to
8 advise on procurement, and the effect of ambitious
9 public policy announcements such as Operation Moonshot
10 on procurement decisions and expenditure.

11 But what of the logistical challenge and the
12 regulation inspections and distribution that went into
13 the procurement exercise? The surge of medical
14 equipment and supplies entering the United Kingdom being
15 produced there and being sold for use in our health and
16 care sectors also increased the burden on our regulatory
17 bodies. The regulators responsible for items that we
18 referred to as PPE are the MHRA and the Health and
19 Safety Executive. Depending on the purpose of the item,
20 it is either classified as a medical device or as
21 personal protective equipment. This means that it falls
22 within the remit of a different regulator, subject to
23 different legislation, and regulations, and must comply
24 with different specifications.

25 On top of this, there are numerous technical
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1 manufacturers of PPE in an attempt to simplify
2 regulatory process, speed it up, and still guarantee the
3 safety of end users. It granted easements for certain
4 items, changing the requirements that suppliers had to
5 comply with. The regulators also assisted DHSC in
6 assessing the compliance of PPE procured by the Parallel
7 Supply Chain.

8 The British Safety Industry Federation, which
9 represents British manufacturers of protective
10 equipment, has expressed the view that, despite all this
11 work, the market was still awash with non-compliant
12 respiratory protective equipment and that this country
13 was similarly unprepared for the value of non-compliant,
14 potentially unsafe PPE which came into the country,
15 often being offered for sale through digital channels.

16 The Inquiry will consider the complex regulatory
17 landscape, how it stood up to the demands of the PPE
18 market during the pandemic and what lessons might be
19 learnt for the regulatory sector.

20 Moving on to distribution. Buying key healthcare
21 related equipment and supplies is only part of the
22 story: their distribution to where they are most needed
23 is just as important. This was a significant challenge.
24 PPE needed to find its way not only to hospitals but to
25 other health and care settings and to local authorities.

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1 specifications with which items must comply in order to
2 be properly marketed as PPE for use in the medical
3 sector.

4 There are a number of ways suppliers can evidence
5 their compliance with these effectively for testing
6 samples of their product in laboratories and gaining
7 a certificate of compliance. Only specific
8 organisations are able to grant such certificates or to
9 endorse compliance with essential technical standards.

10 Different countries have different regulatory
11 regimes. This posed an additional challenge for those
12 procuring PPE during the pandemic, as much of our PPE
13 was imported from other countries.

14 Furthermore, aspects of the UK's withdrawal from the
15 European Union were formalised during the pandemic,
16 including in relation to regulation of medical devices
17 and PPE.

18 The Office for Product Safety and Standards (OPSS),
19 Trading Standards and Border Force, carried out a great
20 deal of work to ensure that non-compliant PPE was not
21 circulating within the UK. The MHRA and Health and
22 Safety Executive worked together and were part of
23 a group set up by the DHSC called the Regulatory
24 Co-ordination Cell.

25 The regulators worked with DHSC and suppliers and
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1 The logistical challenge was immense and should not be
2 underestimated. As the Chief of the Defence Staff,
3 Sir Nicholas Carter stated on 22 April 2020:

4 "In all my more than 40 years of service, this is
5 the single greatest logistic challenge that I have come
6 across."

7 The DHSC contracted out distribution to companies
8 like Clipper Logistics. Initially, the DHSC pursued
9 a push model, a policy of sending shipments of PPE to
10 hospitals based on what was available and what they
11 estimated was needed.

12 As work to understand demand and stabilise supply
13 chains progressed, trusts were able to feed into what
14 their needs were. The enormous volumes of PPE
15 purchased, mainly from China, had to be transported to
16 the UK. Thereafter, a logistics and distribution
17 network had to be created to warehouse, sort and
18 distribute the PPE swiftly across the country. NHS
19 trusts and boards received daily deliveries. Trusts
20 have raised concerns about the performance of Clipper
21 Logistics, the company used to distribute items. They
22 have also raised concerns about the quality of the PPE
23 and difficulties in the early months of the pandemic in
24 obtaining the PPE which they ordered.

25 From 6 April 2020, local resilience forums received
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1 PPE for distribution to social care and other services
2 that could not access PPE supplies in other ways. But
3 most small social care providers and GPs, totally 20,000
4 individual providers, had signed up only until June 2020
5 to a new e-portal that allowed them to order free PPE
6 directly from the Parallel Supply Chain for delivery
7 through the mail service.

8 By the 28 July 2020, DHSC had plugged the gap and
9 was directly supplying PPE to over 58,000 locations,
10 drawing on the help and expertise of the Ministry of
11 Defence.

12 By 27 September 2020, approximately 4.5 billion
13 items of PPE had been distributed to around 58,000
14 locations. This compares with an estimated 2.04 billion
15 items distributed and used in the NHS over the course of
16 the whole of 2019.

17 The NHS supply chain was complex pre-pandemic, with
18 trusts using a number of suppliers to provide PPE. SCCL
19 was designed to serve only 240 NHS trusts and boards
20 and, as at 2018, had an approximate market share of 38%
21 of the market for medical consumables. It is also
22 important to note that SCCL was not, prior to the
23 pandemic, serving as the sole source of supply of goods
24 or PPE to the NHS; it's role therefore changed
25 substantially and dramatically during the pandemic.

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1 army. Wales received PPE from the UK central
2 Government, but also carried out its own procurement of
3 PPE. As at April 2021, Wales had received £880 million
4 through the Barnett formula, as a result of spending on
5 PPE in England. Mark Drakeford has described this as
6 a twin-track approach.

7 On 19 March 2020, Vaughan Gething, Minister for
8 Health and Social Services Group at the time, announced
9 that NHS Wales' services partnership remit would be
10 expanded to include the Social Care Sector.
11 Responsibility for the procurement of PPE in Wales
12 largely stayed in the hands of the NHS Shared Services
13 Partnership, an organisation wholly owned and funded by
14 the Welsh Government but independent of it. This is in
15 sharp contrast to the decision made in England, namely
16 that PPE would be procured by DHSC, essentially in-house
17 by the Government.

18 Procurement decisions for PPE in Wales were thus
19 made by staff at NHS Shared Services Partnership, rather
20 than by civil servants or ministers. NHS Shared
21 Services Partnership is not part of the Welsh Government
22 but carries out procurement for items needed across the
23 NHS in Wales. Staff from NHS Shared Services
24 Partnership also worked, from different health boards
25 across Wales, placing orders for PPE.

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1 I move on now to the devolved administrations. In
2 Wales, Scotland and Northern Ireland, the existing
3 procurement bodies, Scotland NSS, NWSSP, and BSO PaLS,
4 retained their procurement responsibilities for PPE.
5 The result was that arm's-length bodies, separate from
6 central governmental authorities, carried out the
7 majority of the purchasing and distribution of PPE.

8 It is worth noting at the outset that none of the
9 devolved administrations set up an equivalent of the VIP
10 Lane for high-profile referrers or for politicians,
11 elected representatives or industry leaders, nor, for
12 that matter, as far as the Inquiry is aware, did other
13 countries overseas.

14 Turning now more specifically to Wales. In the
15 early stages of the pandemic there were concerns about
16 distribution of PPE and about stock levels of PPE
17 generally in Wales. At points in April 2020, there were
18 less than two days' supply of Type IIR masks and
19 surgical gowns. As the pandemic wore on, Welsh
20 Government, local authorities, the care sector and
21 health boards improved their communication and
22 co-ordination and established ways of working that meant
23 PPE and key medical equipment and supplies were
24 distributed across Wales in an effective way.

25 Wales also received logistics assistance from the

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1 The fluctuations in global prices for PPE were of
2 course also experienced in Wales. NHS Wales' Shared
3 Services Partnership reported that, in terms of price
4 increases, the largest increase was for gloves, which
5 cost 800% of the average pre-pandemic price at the peak.
6 At a local level, local authorities used the National
7 Procurement Network to share information about PPE
8 prices and orders but local authorities were operating
9 independently to place orders and secure their own
10 supplies of PPE. This brought together the heads of
11 procurement from each of the 22 Welsh local authorities.
12 Individual local authorities did not have the same bulk
13 purchasing power as NWSSP and sometimes found themselves
14 paying significantly higher prices than NWSSP.

15 The Welsh National Procurement Service assisted in
16 combatting issues, such as erroneous or fraudulent
17 compliance markings and certificates, and exploitative
18 pricing. While there was some support from NHS Shared
19 Services to local authorities in the early months of the
20 pandemic, arrangements between the NHS Shared Services
21 Partnership and the Welsh Local Government Association
22 were not formalised until 12 October 2020 when NHS
23 Shared Services Partnership formally undertook to
24 provide social care settings with appropriate PPE for
25 the duration of the pandemic.

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1 The Welsh Local Government Association has told the
2 Inquiry that, after the early stages of the pandemic,
3 supplies were distributed equitably across Wales and
4 that there were close collaborative relationships across
5 public sector services in Wales and Welsh Government.

6 A collaborative approach was also taken by Welsh
7 Government at central level. For example, Mark
8 Drakeford established a Covid core group and two leaders
9 of the opposition were invited to attend.

10 Surveys conducted by the Royal College of Nursing
11 suggests that confidence in PPE supply increased over
12 time, including amongst frontline workers. However,
13 Audit Wales identified the need for improvement in due
14 diligence processes and noticed increased risk taking by
15 NHS Shared Services Partnership, including in making
16 large advance payments. NHS Shared Services Partnership
17 did not meet its obligations under the procurement
18 regulations to publish contract award notices within the
19 deadlines.

20 The health and social care system in Wales also
21 struggled initially to gather reliable data on stock
22 levels and usage rates of PPE. NHS Shared Services
23 Partnership asked Deloitte to carry out modelling work.
24 There were challenges in developing reliable models due
25 to discrepancies in adherence to guidance, across

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1 medical supplies and equipment.

2 During the pandemic, NSS was responsible for the
3 procurement of PPE, ventilators, and LFT and PCR tests.
4 Scotland had three main sources of PPE: UK-wide
5 procurement; its own orders from international
6 suppliers; and Scottish-based manufacturers. Lack of
7 PPE and healthcare equipment inventory visibility during
8 the pandemic was identified by the Scottish Government
9 as a clear vulnerability, whilst NSS had knowledge of
10 national stock levels. It did not have access to data
11 for health board inventory held at local department
12 board levels. The Scottish Government had relied on its
13 agreement with the UK Government to replenish stocks of
14 PPE using JIT arrangements with manufacturers. These
15 contracts, however, were ineffective in the face of
16 global market pressures during the pandemic.

17 Centrally held PPE stocks in Scotland were very low
18 at points during April 2020 as PPE was rapidly
19 distributed to Scottish NHS health boards including only
20 0.3 days' worth of stock of long-sleeve gowns, one day
21 of FFP3 masks, and two days' of visors being available.

22 The Scottish Government considered that levels of
23 PPE being delivered to the devolved administrations
24 through UK-wide procurement channels in the early days
25 of the pandemic were limited, which resulted in what it

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1 different health and care settings and unilateral
2 decisions taken in some health boards to provide higher
3 levels of protection to staff than required by guidance.

4 Wales also invested significantly in its domestic
5 manufacturing industries, the Critical Equipment
6 Requirement Engineering Team (CERET), was set up to help
7 Welsh businesses switch their capacity to PPE
8 production. Life Sciences Hub Wales assisted CERET and
9 also sought to stimulate the creation of innovation,
10 medical suppliers and supplies. Wales provided PPE to
11 other nations of the UK through mutual aid arrangements.
12 Wales accepted ventilators on loan provided from England
13 and sourced through the Ventilator Challenge UK. Prior
14 to these ventilators being sourced, there was
15 significant outlay on ventilators or ventilator parts in
16 Wales.

17 Wales also invested in its own Covid test processing
18 capabilities but procurement of LFT, lateral flow test,
19 and PCR test kits was carried out by the UK central
20 government.

21 Moving on to Scotland. In Scotland, National
22 Services Scotland, NSS, acts as a procurement arm for
23 the whole of the NHS in Scotland, with procedures to
24 oversee the due diligence of suppliers, pricing, quality
25 control, distribution and supply of a wide range of

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1 termed significant costs being incurred. There appeared
2 to have been tensions between the Scottish and UK
3 governments over supply chain policy. The Scottish
4 Government wished to continue to procure its own PPE and
5 healthcare equipment in opposition to a UK-wide approach
6 proposed in April 2020.

7 It was agreed on 9 April 2020 that the UK Government
8 would continue to buy at best efforts for the UK, but
9 devolved governments were continuing direct procurement
10 also.

11 As the level of global demand and increased pricing
12 posed severe challenges to health and social care
13 provision outwith the hospital settings, the Scottish
14 Government took the decision to supply these settings of
15 primary community and social care directly, setting up
16 new order and distribution routes and securing
17 equipment, to allow two companies in Scotland to produce
18 items of PPE through the creation of domestic supply
19 chain.

20 NHS NSS distributed 1.1 billion-items of PPE between
21 March 2020 and April 2021. NSS set up regional hubs to
22 distribute PPE to social care providers, unpaid carers
23 and personal assistants, and provided PPE to primary
24 care providers directly, or through arrangements with
25 NHS boards. NSS awarded new PPE contracts using

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1 emergency procurement procedures, but has been
2 criticised for the fact that contract award notices were
3 not published within the required timescales for most of
4 the PPE contracts which reduced the transparency of
5 decision making.

6 On testing, the Scottish Government did not procure
7 PCR tests or lateral flow devices directly, as this was
8 done on a four nations basis.

9 Testing capacity through the purchase of equipment
10 and testing consumables.

11 In 2021, Scottish ministers agreed to loan the UK
12 Government millions of lateral flow tests. The UK DHSC
13 did offer to supply ventilators to NHS Scotland. Two
14 NHS health boards trailed a ventilator model from the
15 Ventilator Challenge in May 2020 but Scotland's ICU
16 Resilience and Support Group decided that these did not
17 meet NHS Scotland requirements and requested that
18 Scotland's allocation should be held by the DHSC in
19 reserve, in the event of an extreme surge scenario.

20 Alongside efforts to secure additional ventilation
21 equipment, the ICU Resilience Group undertook to
22 repurpose anaesthetic machines to mitigate against any
23 potential shortage of ventilators which, in Scotland,
24 was considered less of a risk to the NHS than utilising
25 unfamiliar brands of ventilators, especially when the

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1 of Procurement Expertise (CoPE). The relevant CoPE to
2 all DHSC organisations in Northern Ireland is the
3 BSO PaLS, an arm's-length body of the Department of
4 Health. BSO PaLS provides all procurement services to
5 HSC trusts say for construction procurement, which is
6 managed by another CoPE.

7 Prior to the pandemic, BSO PaLS produced nearly all
8 the PPE used in Northern Ireland, although individual
9 HSC trusts do have the right to procure independently.
10 The Department of Health estimates this accounted for
11 less than 1% of PPE procurement. In 2019, BSO PaLS
12 purchased just under £3 million of PPE, primarily
13 through four fixed-price contracts awarded through open
14 competition. This included £2.7 million spent through
15 its own contracts, 95% of which related to gloves and
16 aprons. BSO PaLS also spent 0.2 million on FFP3 masks
17 through the NHS supply chain frameworks. In respect of
18 ventilators, BSO PaLS did not procure ventilators
19 directly but facilitated and advised on their purchase
20 by HSC trusts.

21 Planning and decision-making process in relation to
22 the quantity and other type of ventilator and other
23 critical care equipment required were led by the
24 Critical Care Network Northern Ireland. Northern
25 Ireland also received ventilators from the national

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1 workforce was already under such pressure.

2 NHS Scotland also secured equipment on loan from the
3 UK DHSC, with Scotland allocated up to an 8.2% share of
4 all the equipment procured or stockpiled and a small
5 number of ventilators were accepted of brands familiar
6 to NHS Scotland.

7 Following the pandemic, the Scottish Government
8 consulted on increasing levels of centralisation of
9 purchasing and supply of PPE and other healthcare
10 equipment on behalf of all public sector organisations
11 and social care providers, and is looking at extending
12 the remit of the NSS to become responsible for all
13 public sector buying of PPE and healthcare equipment in
14 Scotland, including for health boards and local
15 authorities, as well as managing the pandemic stockpile.

16 The Scottish Government believes greater levels of
17 centralised procurement for all related public
18 organisations on a national basis is the best solution.
19 The extent to which this solution might help a UK-wide
20 pandemic response will be examined.

21 Moving now to Northern Ireland. In Northern
22 Ireland, the Department of Health is responsible for
23 health and social care, which is provided by five health
24 and social care trusts. Departments of the Northern
25 Ireland Executive are required to be advised by a Centre

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1 stock that were required by NHS England.

2 BSO PaLS was not responsible for the PIPP stockpile
3 in Northern Ireland, which is owned by DHSC. DHSC
4 solely determines the type and volume of products held
5 in the stockpile but the Department of Health has
6 ownership and authority to release times and BSO PaLS
7 provides a storage, maintenance and stocktaking service.
8 Uniquely among the nations of the UK, Northern Ireland
9 also held a small stockpile of gowns, which had been
10 acquired by the Department of Health in preparation for
11 a possible outbreak of swine flu in 2009. Through
12 engagement between their respective CNOs, 25,000 gowns
13 were sent to England by Northern Ireland in mutual aid.

14 In the early stages of the pandemic, BSO PaLS
15 amended its procurement processes and engaged in more
16 negotiated spot buying rather than its usual competitive
17 tendering. The Northern Ireland Audit Office report in
18 March 2022 found that BSO PaLS relied heavily on direct
19 award contracts throughout the first wave of the
20 pandemic. Between February and November 2020, BSO PaLS
21 and the Department of Health awarded more than 70 DACs
22 with a total initial estimated value of £549 million.

23 On 25 June 2020, BSO PaLS established a Dynamic
24 Purchasing System (DPS), for PPE, in order to reduce
25 reliance on direct award contracts and move towards

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1 a more competitive process. As of March 2022, it had
2 awarded only two competitive contracts under this,
3 totalling £38.3 million. This may reflect the large
4 stocks built up under the emergency regulation
5 contracts.

6 BSO PaLS worked with the Medicines Optimisation
7 Innovation Centre (MOIC), on a process whereby all PPE
8 offered by new suppliers was tested to ensure all
9 applicable standards were met. Following due-diligence
10 checks by BSO PaLS, the MOIC would carry out
11 a pre-procurement assessment involving a technical
12 assessment and physical wear test by Public Health
13 Agency professionals.

14 By May 2020, about 45% of over 600 individual PPE
15 products had failed this technical assessment. Once
16 a product from a supplier met the technical clinical
17 assessment for MOIC, BSO PaLS would negotiate with the
18 suppliers on price and payment terms, and place
19 an order. BSO PaLS, along with Invest Northern Ireland,
20 Construction and Procurement Delivery and the Department
21 of Health had some success in encouraging local
22 businesses to begin manufacturing PPE or scaling up
23 existing production. This resulted in the award of
24 seven contracts to local businesses with the total
25 estimate value of £165.8 million.

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1 administrations. I move now to the final section of
2 these opening submissions, which relates to the approach
3 that has been adopted, and that my Lady may wish to
4 adopt, to lessons learned and recommendations.

5 In considering the very significant quantity of
6 evidence which has been gathered by this module to date,
7 some key themes have emerged. These include: first, the
8 centrality of data to good procurement; second,
9 diversification of supply and its need; third, domestic
10 manufacturing capacity; fourth, fairness in emergency
11 procurement; and fifth, linked to that, transparency.

12 So dealing with those in turn. First, the
13 centrality of data to good procurement. There was very
14 little data available to ministers and officials on
15 which to base sound procurement decisions. This data
16 deficit in practice affected almost every aspect of
17 procurement.

18 It is clear that the governments of the UK and
19 devolved administrations all struggled to obtain clear
20 pictures of the inventories of PPE within both their
21 health and social care sectors and the rates at which
22 that PPE was being used.

23 As it was difficult to keep track of usage rates, so
24 it was with anticipated demand. What data did the UK
25 Government and devolved administrations have on the

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1 The Northern Ireland Audit Office commented that
2 local manufacturers have contributed significantly
3 towards strengthening local supply chains and their
4 continued involvement will be key to ensuring stronger
5 and more sustainable supply confidence.

6 Uniquely among the nations of the UK, social care is
7 managed by the Department of Health in Northern Ireland,
8 rather than being within the remit of the local
9 authorities and, therefore, BSO PaLS was responsible for
10 procuring PPE for their own care homes. However, the
11 independent care sector responsible for many care homes
12 and domiciliary care in Northern Ireland would usually
13 procure their own equipment. In Northern Ireland there
14 were particular concerns around the PPE availability in
15 independently-run care homes and providers of
16 domiciliary care, who would source their own PPE in
17 normal times.

18 The Department of Health issued guidance saying that
19 where ISPs were unable to source adequate PPE supplies,
20 trusts would provide support. However, there were
21 concerns that this did not adequately address the
22 shortages and some care homes reported having to make
23 their own PPE or making appeals for equipment from the
24 community, charitable and commercial sectors.

25 My Lady, that concludes the sections on the devolved

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1 make-up of their health and social care workforce? How
2 did this contribute, if at all, to the decisions to
3 procure? The evidence will show that this ought to be
4 a critical factor taken into account in future emergency
5 procurement.

6 The situation for those responsible for purchasing
7 was, it appears, aggravated by an absence of accurate
8 realtime tracking of the volumes of PPE available on the
9 open market, of what was being purchased, and of
10 information such as prices, technical specifications,
11 delivery times, and available contract terms.

12 In a global market in such extreme flux as that
13 which confronted the UK as it entered the pandemic,
14 access to such kinds of information would have put those
15 taking procurement decisions at a clear advantage. In
16 an imperfectly functioning market, information is itself
17 a valuable commodity to buyers. How can we better arm
18 those making procurement decisions in the future with
19 better data?

20 One of the consequences of the PPE call to arms was
21 that the procurement system was deluged with offers
22 which meant that it had no means by which the
23 information contained within those offers could be
24 analysed and triaged at speed.

25 This itself was aggravated by many stages of the

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1 DHSC's eight-stage procurement process. As data about
2 such matters as due diligence and technical
3 specifications was sought out and provided, even larger
4 pools of information accrued. Each pool had to be
5 analysed and triaged by specialist teams before a final
6 decision could be taken on whether a contract should be
7 entered into.

8 The IT and software systems which officials were
9 required to use did not allow them to work effectively
10 together. Under the considerable pressure of the
11 procurement effort, they were required to rely on
12 cumbersome systems based on an exchange of spreadsheets
13 and formed by emails to put together the pieces of an
14 offer.

15 The consequence was a manual, labour-intensive and
16 potentially less effective and efficient approach than
17 it could otherwise have been.

18 Better use. How can there be better use of data, in
19 both procurement and technology, in its interrogation,
20 is a key issue in this model. It ought to be possible,
21 we think, for the governments of the UK and devolved
22 administrations to rely on a procurement system driven
23 by access to live data about inventory, the market, and
24 offers of supply.

25 Diversification of supply, the second theme.

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1 strategy to support and complement an international
2 trades strategy in which support chains are diversified?
3 Are there areas at which the UK is at a comparative
4 advantage? Are there lessons in which the UK might
5 learn from the approaches taken by the devolved
6 administrations? We think that there are and we will
7 explore them in the hearings.

8 Penultimately, fairness in emergency procurement.

9 It ought not to be forgotten that the enormous sums
10 spent during the pandemic are, of course, public money.
11 Even, and perhaps especially, in an emergency, this
12 Inquiry considers that in the expenditure of such money,
13 fairness and transparency, which I'll move to in
14 a moment, are essential.

15 In order to retain public confidence in the
16 propriety of procurement decisions for which the public
17 bears the cost, there should be a level playing field.
18 What does this mean? That government contracts, both
19 access to, and the award of, should be based on clear
20 and objective criteria. Did the High Priority Lane or
21 the VIP Lane operate in accordance with such principles?
22 It does not appear that it did, but we will examine this
23 in detail over the coming hearings.

24 Now, as I said I would, I turn finally to
25 transparency, very much linked to fairness.

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1 The UK placed considerable reliance on a relatively
2 small number of countries to supply it with healthcare
3 equipment and supplies. Was this the right approach?
4 It created a grave risk that in the event of a global
5 pandemic, global supply chains, generally emanating from
6 a small number of countries and focused on China, would,
7 as they indeed did, cease to function.

8 If the diagnosis is correct, then one of the
9 prescriptions is relatively clear. The Inquiry will
10 hear evidence to the effect that diversification of
11 supply chains for such equipment to include a wider
12 range of countries and regions is a necessary step to be
13 taken to improve resilience.

14 The UK would thereby benefit from a more robust
15 emergency international buying strategy in the event of
16 a future pandemic.

17 Be what about domestic manufacturing capacity? The
18 UK's international buying efforts were complemented by
19 the scaling-up of domestic manufacturing. A small
20 number of strategic suppliers were selected and provided
21 with support by the UK Make team. Is there scope for
22 such support to be broadened to include a wider range of
23 domestic manufacturers, and improved in terms of the
24 speed and technical support which is available?

25 Is there scope for a domestic emergency industrial

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1 Finally, transparency, an important part of the work
2 of this module, is to open up the systems, the systems
3 which expended so much in such a short period of time,
4 to public scrutiny. Much has been speculated and
5 written about the decisions of those involved in
6 procurement on behalf of the UK Government and devolved
7 administrations during the pandemic.

8 Our starting point is that the public has a right to
9 know how their money was spent in the name of protecting
10 them from the pandemic. For procurement decisions in
11 the future to be better and represent value for money,
12 there needs to be more and not less transparency. As
13 much as can be published about contracts entered into
14 during an emergency should be published. We will
15 explore the limitations of this approach and how best it
16 may be achieved in the future.

17 My Lady, those conclude the opening submissions made
18 on behalf of the Inquiry.

19 **LADY HALLETT:** Thank you very much indeed, Mr Wald.

20 A number of Core Participants wish to make oral
21 submissions. I don't wish to have to interrupt so I'm
22 afraid I'm going to insist that people stick to their
23 allotted time.

24 Mr Weatherby.

25

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1 **Submissions on behalf of Covid-19 Bereaved Families for**
 2 **Justice by MR WEATHERBY KC**

3 **MR WEATHERBY:** Thank you.

4 At paragraph 99 of his witness statement,
 5 Michael Gove states:
 6 [As read] "Much has been written, broadcast and
 7 tweeted about the so-called scandal of PPE procurement.
 8 Almost all of it has been politically-motivated bilge."

9 In terms of political motivation, Mr Gove and others
 10 can be assured that the 7,000 family members we
 11 represent no doubt reflect the voting spread of the
 12 population including across the four nations and
 13 jurisdictions. The bereaved just want to know simple
 14 answers to compelling questions:

15 Why, apparently, was there no emergency planning for
 16 supply chain disruption and surging demand which is
 17 entirely foreseeable in a whole system emergency?

18 Why were there only business-as-usual and
 19 just-in-time procurement processes in place when it was
 20 obvious that these would fail, as happened with the main
 21 healthcare supplier Supply Chain Coordination Limited?
 22 Why was there such limited stockpiling and no central
 23 data system to know where stocks were or shortages were
 24 arising?

25 Why was there no emergency procurement process
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1 the evidence amassed by the Inquiry, that certain
 2 politically-connected individuals gained massively from
 3 contracts to supply PPE and medical provisions during
 4 the pandemic.

5 Some companies failed to deliver what they were paid
 6 for. There was profiteering and price gouging and
 7 processes which led to businesses effectively bidding
 8 against each other, inflating prices.

9 To that end, we're pleased that the Inquiry is to
 10 look at nine example contracts. However, regrettably
 11 and to the dismay of the families, the Inquiry has
 12 chosen not to call any of those who were the suppliers
 13 in the questionable contracts.

14 Of course, the determination of which witnesses are
 15 called to give evidence is for you, but no disrespect is
 16 intended in my setting out the concerns of the families.

17 The High Court has already found that the VIP Lane
 18 breached the obligation of equal treatment, potential
 19 suppliers and middlemen, many of whom were in that lane
 20 through political patronage and networking, the very
 21 things that are anathema to the essence of public
 22 procurement regulation.

23 Having considered evidence from some witnesses who
 24 will appear before the Inquiry which indicated that VIP
 25 offers were not advantaged at the decision making stage,
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1 concentrating on existing suppliers, rather than
 2 a VIP Lane and a desperate shout-out to unknown and
 3 opportunist profit seekers?

4 Why did nurses face having to make their own PPE
 5 from bin liners whilst others lined their pockets?

6 Did businesses gained preferential access to
 7 procurement processes because of political patronage?

8 In addition to the statistics Mr Wald has given, the
 9 Inquiry expert has indicated that the VIP Lane accounted
 10 for almost 50% of the purchases via the PPE Buy Cell.
 11 No other country operated a VIP Lane which catered for
 12 friends of government ministers, so why did the UK?

13 For the families, this isn't about the political
 14 point scoring; it's about scrutiny. Scrutiny as to
 15 whether cronyism, unfair advantage, corruption, allowed
 16 chancers to make fabulous profits at the expense of all
 17 of us, the bereaved, key workers, those legitimately
 18 doing everything they could to fill the gaps resulting
 19 from an absence of planning, and of course, at the
 20 expense of the public purse.

21 In the coming days the Inquiry will have the
 22 opportunity to ask Mr Gove to assist us with which parts
 23 of the scandal are politically motivated nonsense and
 24 which are, in fact, not nonsense. Because it really is
 25 beyond argument from open source material, never mind
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1 the High Court concluded that, and I quote:

2 "... Speed in getting an offer to Technical
 3 Assurance improved the chances of securing a contract."

4 In fact the Inquiry expert and the open evidence of
 5 Richard James, a commercial specialist within the
 6 Complex Transactions Team at the Cabinet Office,
 7 suggests that the advantage went further than that.

8 Professor Sanchez-Graells points to the effect of
 9 pressure for regular updates from VIP referrals on
 10 time-strapped civil servants, whilst Mr James indicates
 11 that access through the VIP Lane not only gave the
 12 advantage of speed and dedicated updating, but direct
 13 and dedicated contact with the Technical Assurance team
 14 to overcome reasons which might lead to refusal.

15 By putting this evidence aside for a moment, the
 16 families ask: if the VIP Lane did not advantage those
 17 using it, what was its purpose? As the High Court made
 18 clear, there were various factors which justified
 19 expediting an offer under an emergency process. The
 20 political status of the offeror or referrer were not
 21 amongst them.

22 By not calling the suppliers, the Inquiry has
 23 deprived itself of calling to account those for whom
 24 political patronage appears to have been a key element
 25 of getting the contract. It's deprived itself of being
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1 able to ask them how they came to make their bids, to
2 explain their commercial expertise and experience and
3 history in the areas they sought to supply, it's
4 deprived itself of the opportunity to ask questions as
5 to whether their attempts to source supplies interfered
6 with established suppliers' efforts and drove up prices.

7 Were these legitimate intermediaries who could add
8 value or chancers who saw opportunities to use their
9 political connections and the misery of others to make
10 huge, unwarranted profits?

11 For example, the Inquiry will not be able to ask
12 David Meller of Meller Designs Limited, a donor to the
13 Tory party and to Mr Gove's leadership campaign in 2016,
14 how his company, a fashion house, was in a better
15 position to source PPE than firms which had specialised
16 in doing just that for years.

17 In referring him to the VIP Lane, Lord Feldman had
18 noted that he was "a good friend of Mr Gove".

19 Mr Gove's private office chased up the bids asking
20 them to be dealt with as "a matter of urgency."

21 We've set out some of the detail at paragraph 65 of
22 our written submissions for anyone who wants to look at
23 it, but why was a fashion house, with pre-pandemic
24 profits of £143,000, being so heavily promoted by
25 ministers? Meller Designs' profits rose by £13 million

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1 Lord Chadlington, referrer of the SG Recruitment bids,
2 Member of the House of Lords, director of
3 SG Recruitment's holding company, about his influence in
4 the contracts, contacting David Cameron and
5 Lord Feldman.

6 In his case, you have a statement, but he's not to
7 be examined on it. He appears to accept that he stood
8 to gain indirectly from these contracts, but to what
9 extent did he make clear his potential conflict of
10 interest? The correspondence between Lord Chadlington
11 and David Sumner shows an alacrity at the magnitude of
12 the contracts awarded. Was that because they were
13 celebrating their public spirited contribution to
14 alleviating the affects of the pandemic or was it
15 because they stood to make large amounts of money?

16 Reference to the share price in those communications
17 may give us a clue to that but asking them directly
18 would provide clarity.

19 Maybe the owners of these companies have answers;
20 maybe they don't. One of the roles of a public inquiry
21 is to allay public concern. There's widespread concern
22 regarding these and other contracts. The disappointment
23 of the families will be shared by many and the decision
24 not to call these suppliers will be seen as a lost
25 opportunity to establish the true facts and bring

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1 as a result. A significant volume of the goods supplied
2 were unfit for NHS use.

3 The Inquiry is not able to ask David Sumner of
4 SG Recruitment how it, as a recruitment agency, with
5 a turnover of about £500,000 per annum, and which made
6 a £700,000 loss pre-pandemic, was in a better position
7 to source PPE than those in the business.

8 Again, we set out the details in our written
9 submissions at paragraph 62 but some of the detail is
10 confusing to say the least.

11 What we do know is that SG was awarded contracts
12 worth at least £50 million and correspondence between
13 Mr Sumner himself and Lord Chadlington refers to
14 expected revenues of £135 million, and that officials
15 commented that the prices paid were expensive, even for
16 the state of the market at that time.

17 Evidence also suggests that some of the goods
18 provided through this company were unfit for use and
19 some of the goods, hand sanitiser, was sourced from
20 a Scottish company, which had already supplied the NHS,
21 raising the prospect of this intermediary bidding up the
22 price for existing market suppliers.

23 We also know that in time the holding company went
24 into liquidation, raising further questions regarding
25 public funds. The Inquiry is also not calling

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1 a measure of accountability.

2 As we know, other processes are looking into the
3 recovery of public funds, and there are ongoing criminal
4 investigations also. Those are not the concerns of the
5 Inquiry.

6 As a matter of law, as has been referred to,
7 although Section 2(1) precludes you determining
8 liability, what has not been mentioned is that the
9 corollary is that other parallel processes are not to
10 inhibit this process, and that's Section 2(2) of the
11 Inquiries Act.

12 With respect to Mr Dyson, he was apparently
13 championed by both Mr Gove and the then Prime Minister
14 Mr Johnson. Mr Dyson is the well known vacuum
15 manufacturer, he took part in the Ventilator Challenge.
16 By April it was clear that his model would not be
17 pursued due to clinical viability and functionality.
18 Nevertheless, Lord Agnew, a minister, warned the
19 Government Chief Commercial Officer, Sir Gareth Rhys
20 Williams, in the following terms:

21 "We're going to have to handle Dyson carefully.
22 I suspect we'll have to buy a few machines, get them
23 into hospitals, so that he can then market
24 internationally, being able to say that they are being
25 used in UK hospitals. We both need to accept that it

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1 will be a bigger decision than we can both make.
2 Remember that he got a personal call from the PM. This
3 can't be ignored."

4 As we will hear, the Inquiry expert, Professor
5 Sanchez-Graells, described how Dyson was treated as
6 an affront to the procurement rules.

7 Finally, this morning you heard impact evidence. In
8 our written opening, paragraphs 14 to 25, we set out
9 powerful accounts from a number of family members
10 illustrating the desperation they felt at the lack of
11 available PPE and medical equipment, and their belief
12 that it may have contributed to their loved ones
13 contracting Covid.

14 Dr Glen Grundle's mum died in hospital in April
15 2020. Many of the staff had no PPE. A ceiling of care
16 was set to maintain her on a ward rather than admit to
17 ICU or provide ventilation. Dr Grundle suspects this
18 was related to extreme pressure on supplies.

19 Janice Glassey was an NHS worker who worked with the
20 team who gave end-of-life care to those discharged home
21 for their final days. Her daughter, Kerri, recounts
22 that Janice complained to her of a shortage of PPE and
23 hand sanitiser at her work. She contracted Covid and
24 died.

25 These and many more are the human costs of no proper

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1 bear in mind that mistakes and missed opportunities, and
2 the allegations of profiteering so powerfully addressed
3 by Mr Weatherby before the break, had real world
4 consequences.

5 Those consequences were felt at the time by
6 frontline staff and their patients on hospital wards, in
7 care homes and in their own homes, and they continue to
8 have consequences, measured now by the ongoing impact on
9 political confidence in the top echelons of government.

10 It is hoped that the evidence you will consider in this
11 module will enable you to make strong recommendations to
12 minimise, so far as possible, frontline consequences in
13 any future pandemic or health crisis, but it is also to
14 be hoped that those witnesses from whom you will hear
15 will carefully consider the evidence that they give
16 against the need for this public inquiry to go some way
17 to restoring public confidence.

18 My Lady, real world consequences. Witnesses,
19 including representatives of the Northern Ireland Covid
20 Bereaved, from whom you have heard in earlier modules
21 and from whom you will hear in future modules, have
22 provided powerful evidence of impact. In our written
23 opening, we remind you of the experience of
24 Bridget Halligan, the mother of Agnes McCusker, of
25 Basil Elliot, the brother of Anne Elliot, who at

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1 planning or stockpiling and the diversion of efforts to
2 the VIP and High Priority Lane.

3 Thank you, my Lady.

4 **LADY HALLETT:** We shall break now and I shall return at
5 2.05 pm.

6 **(1.05 pm)**

7 **(The Short Adjournment)**

8 **(2.05 pm)**

9 **LADY HALLETT:** Ms Campbell.

10 **Submissions on behalf of NI Covid-19 Bereaved Families for
11 Justice by MS CAMPBELL KC**

12 **MS CAMPBELL:** Thank you, my Lady.

13 My Lady, your task in the coming weeks is to examine
14 and make recommendations about the procurement and
15 distribution of healthcare equipment and supplies so
16 that in any future crisis we are better prepared and
17 better protected.

18 To do that, you will embark upon a high level of
19 plans, structures, communications, contracts and supply
20 and distribution chains. So packed is your schedule in
21 this module that for the first time you will not hear
22 direct evidence from the bereaved or others impacted by
23 delayed or inadequate PPE and medical supplies, but as
24 you navigate the evidence from the top of the
25 procurement decision-making models, you will, I know,

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1 separate times and in separate locations were two of the
2 many people in Northern Ireland who died having
3 contracted Covid in the care homes in which they lived.

4 Their respective families and many others raised
5 repeated concerns about the availability and inadequate
6 use of PPE which they believe caused their loved ones
7 their lives.

8 Michael Mallon, a father of four, was admitted to
9 Craigavon hospital for a non-Covid related reason in
10 February 2021. He requested a clean fluid-resistant
11 surgical mask only to be told that they were only
12 changed every three days. He contracted Covid whilst in
13 hospital and died whilst isolated from his family.

14 Seamus Anderson, who died in July 2021 in
15 Altnagelvin hospital, his wife Geraldine had asked if he
16 could be placed on an ECMO machine, which she understood
17 would have assisted him, only to be informed that there
18 were none available. Understandably, Geraldine is
19 concerned that a potential shortage of life-saving
20 equipment cost her husband his life.

21 My Lady, we anticipate you will find support for all
22 of these concerns and more in the evidence that you will
23 hear and read in this module.

24 We have an aging hospital and care estate with often
25 no mechanical ventilation, reliant entirely on natural

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1 ventilation. And you will hear from the Royal College
2 of Nursing that our frontline nurses repeatedly raised
3 concerns about the lack of access to PPE and FFP3 masks
4 in that environment.

5 Evidence from trusts reveal that frequent changes to
6 PPE guidance, with the potential for multiple versions
7 of guidance in circulation at any given time, led to
8 staff confusion. That confusion, when combined with
9 stocks on wards visibly running lower, hour by hour,
10 meant that the healthcare environment was frightening
11 for staff and for patients.

12 You will learn that some PPE was received by trusts
13 without EU certification, leading to concerns about the
14 protection it offered. Some goggles were non-compliant
15 with guidance, not fully enclosing the eye area. Aprons
16 were not compatible with PPE dispensers, perforated
17 edges, poorly manufactured, ripping from one apron to
18 the next, making them unusable, some too short to
19 adequately protect uniforms.

20 And, my Lady, you will hear of the recurring impact
21 of the availability of types of FFP3 masks which
22 frequently changed with little or no notice. With each
23 new mask introduced there was an inevitable consequence
24 on fit testing, with staff having to attend on multiple
25 occasions due to changes in mask availability.

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1 unprecedented with overall demand rising by 429% at
2 a time of intense global demand. The evidence you will
3 hear presents a very concerning picture about
4 preparedness for that level of demand, both at
5 a devolved and UK level, but before turning to that,
6 a word on how stock as was available was to be
7 distributed domestically in Northern Ireland.

8 You have heard many witnesses over the course of
9 this Inquiry stressing the benefits of our integrated
10 health and social care system. You also know, indeed
11 I addressed you on it at a recent preliminary hearing,
12 that within our care sector 90% of care homes are
13 privately owned, some under the large umbrella of large
14 providers, some individual family-run care homes.

15 And yet, in an environment in which even BSO PaLS or
16 the UK Government were struggling to get its place in
17 the market, the Department of Health guidance issued in
18 March 2020 outlined that independent care providers were
19 to source their own PPE, and that trusts should only
20 provide PPE to them when suspected or confirmed Covid
21 cases arose.

22 The result was that throughout March 2020,
23 independent care homes received only a small amount of
24 PPE, when already in crisis, and the considerable
25 shortages in that sector were not addressed, much less

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1 My Lady, when one just 1% of staff in one trust had
2 been incorrectly fit tested for the available mask, this
3 affected over 1,300 frontline staff in the pandemic.

4 Problems that in non-pandemic times would perhaps be
5 surmountable, take on much greater impact when staff and
6 patients are at extreme risk, are frightened or
7 exhausted and are isolated.

8 So what went wrong?

9 It is fair to observe that BSO PaLS may not warrant
10 the same level of criticism or concern as their
11 counterparts in Westminster. It is clear that efforts
12 were made to increase stockpiles as a matter of urgency,
13 even though emergency planning for stockpiles did not
14 ordinarily fall within BSO PaLS remit. That was
15 a responsibility owned by the DHSC.

16 As it happened, tripling the peacetime PPE
17 stockholding from four weeks to 12 weeks in late
18 January 2020 proved wholly inadequate, equating to just
19 one week's supply in pandemic terms.

20 Why did BSO PaLS have to takeover stockpiling from
21 the DHSC? What were BSO PaLS told to prepare for as
22 a worst-case scenario? And what lessons have been
23 learned? How adequate are plans for the future? These
24 are questions that we would like publicly answered.

25 We recognised that the workload of BSO PaLS became

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1 were the vulnerability of its residents.

2 The position for domiciliary care is still worse.

3 In an email from the CEO of the Independent
4 Health -- IHCP written on 23 March 2020, fear and
5 frustration is encapsulated about the lack of immediate
6 answers to the availability of PPE in the domiciliary
7 sector:

8 [As read] "The advice about 'stay at home' and
9 'socially distance' [she writes] does not apply to staff
10 in our sector who continue to work without PPE. We have
11 23,000 people every week receiving domiciliary care.
12 Social distancing is impossible and this is a high risk
13 area for transfer yet no one is taking this seriously."

14 She details a call with the director of Mental
15 Health, Disability and Older People in the Department of
16 Health in which she was told:

17 [As read] "Medical advice is that domiciliary care
18 workers don't need masks, don't need to socially
19 distance, and just need to wash their hands frequently."

20 Despite her efforts, she could not get the
21 Department of Health to see the problems with this
22 paradox of information to care workers, and she notes
23 that she gave up her efforts after an hour.

24 It may be, my Lady, that the Department of Health
25 position in relation to medical advice and the

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1 distribution of PPE to the independent sector changed
2 within a matter of weeks, at least for care homes. But
3 those were critical weeks, and the consequences, we
4 know, for those who lived in care home and for families
5 who now grieve them were catastrophic.

6 So we anticipate that we will ask you consider
7 a recommendation that never again can the Department be
8 so ill prepared or delegate its responsibility to the
9 independent sector.

10 My Lady, you know well that those are not the only
11 concerns of the Northern Ireland Covid Bereaved. While
12 procurement from Belfast has not been subject to the
13 same accusations of profiteering or cronyism as
14 procurement from London, that is not to say that what
15 was happening in London did not impact in Belfast. Nor
16 is it to say that there are not domestic improvements
17 that can be identified through strengthening supply
18 chains, ensuring transparency, leaving a clear audit
19 trail of transactions and identifying conflict of
20 interest in ensuring data storage. We are particularly
21 concerned about an apparent complete loss of all emails
22 and messages emanating from the Northern Ireland Bureau
23 representative in China, precluding any examination of
24 their contact. And we anticipate that by the end of
25 this module you will have good reason to make strong

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1 before the Secretary of State Matt Hancock's proposed
2 UK-wide protocol to support collaborations on the
3 sourcing and supply of PPE would be issued for
4 consideration by the devolved administrations in
5 May 2021. Too little? Quite possibly. Too late? Most
6 definitely.

7 My Lady, I end with a reminder that the cost of
8 failings that you will consider in this module is not
9 only to be identified at the bottom of a bank balance or
10 on a balance sheet, the Northern Ireland Covid Bereaved
11 continue to pay an enormous price through their grief,
12 which is immeasurable and which must not be repeated.

13 Thank you.

14 **LADY HALLETT:** Thank you very much indeed, Ms Campbell.
15 Ms Parsons.

16 **Submissions on behalf of Covid-19 Bereaved Families for
17 Justice Cymru by MS PARSONS**

18 **MS PARSONS:** My Lady, this is the opening statement on
19 behalf of the Covid-19 Bereaved Families for Justice
20 Cymru.

21 The importance of this module for this group cannot
22 be overstated. Right across Wales, whether in
23 hospitals, care homes, hospices, members witnessed
24 firsthand shortages in PPE and equipment.

25 More tragically, they experienced those shortages

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1 recommendations in each of those areas.

2 My Lady, before I conclude, a word about
3 co-ordination with the devolved administrations. In
4 other modules we have addressed you about the lost month
5 of February, when time slipped through fingers like sand
6 through an hourglass, but does this module also expose
7 that there was a lost month of March? Andy Wood, the
8 lead for PPE Buy Cell from whom you will hear this week,
9 sent an email on 22 March 2020 with a ten-point list of
10 basic requirements if he was to, as he put it, stand
11 a chance of success.

12 It's a fair observation that that list tells a tale
13 of starting from scratch. He needs technical assurance,
14 international logistics, new supplier hunters,
15 governance, data, logistics, warehousing.
16 22 March 2020, my Lady, the day before lockdown,
17 starting from scratch.

18 It might be thought unsurprising against that
19 background that two months later, in May 2020, the
20 devolved administrations were individually and
21 collectively raising concerns about an absence of
22 a four nations approach to procurement, and about a lack
23 of transparency about procurement decisions taken by the
24 DHSC apparently on behalf of four UK nations.

25 My Lady, it would be a full ten months after that

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1 firsthand, and so they asked themselves: would more and
2 better PPE have saved the lives of their loved ones?
3 Would more and better access to CPAP, oxygen,
4 ventilators have made the difference? Of course,
5 questions like this on an individual level are not the
6 matter for the Inquiry. But the collective testimony of
7 this group, its collective voice, speaks to the
8 existence of sustained and systemic problems in Wales.

9 Mark Drakeford, First Minister, Vaughan Gething,
10 Minister for Health and Social Services, amongst others
11 in the Welsh Government, have prepared statements for
12 this module.

13 They claim that Wales, on a national level, never
14 ran out of PPE. They claim that Wales was never short
15 of ventilators. Indeed, the picture today, presented in
16 opening, was rather rosy: teething problems, yes, but
17 a well established equitable way of distribution was
18 established in Wales in due course, characterised by
19 close collaboration at all levels of government.

20 My Lady, it is a rosy picture that the members of
21 the group will not recognise. Their questions remain:
22 why did they witness such appalling shortages in PPE,
23 not just in wave one, but in later waves? Why did they
24 experience delays in accessing vital equipment and
25 supplies?

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1 Against that main point, that backdrop, I flag some
2 specific concerns: first and foremost, nosocomial
3 infections. At the pandemic went on, families in Wales
4 felt it was a grim inevitability that, if admitted to
5 hospital during the pandemic, their loved one would
6 catch Covid. Their fears were well founded. Data from
7 Public Health Wales showed that, as of 24 February 2021,
8 of patients in Welsh hospitals testing positive for
9 Covid, 53% caught it in hospital.

10 The issue, as ever, is best expressed by the words
11 of the group's members. Anna-Louise Marsh-Rees,
12 co-leader of the group, her father caught Covid in
13 hospital in October 2020, as did 21 others on his ward,
14 of which 12, including her father, sadly passed away.
15 Her father had to wait 40 minutes for a high-flow oxygen
16 machine. The hospital confirmed it was being used
17 elsewhere.

18 Ann Marie Richards, her husband caught Covid in
19 hospital in December 2020, as did 25 other patients and
20 25 staff members. Tragically he never recovered.
21 Hywel Dda health board told Ms Richards rather opaquely,
22 and I quote:

23 [As read] "Exposure to multiple hospital
24 environments would have made Mr Richards more vulnerable
25 to hospital acquired infections."

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1 overlooked. There were problems with supply of PPE.
2 There were problems with supply of appropriate PPE.
3 There were problems with guidance, targeted as it was to
4 a hospital setting.

5 On 19 March 2020, as we heard this morning, the
6 Welsh Government announced that Shared Services had
7 expanded its reach to the Social Care Sector. But by
8 May 2020, only two-thirds of care homes were supplied by
9 Shared Services, the remainder, presumably, having to
10 make their own arrangements and, as the Welsh Local
11 Government Association observe, problems in supplies
12 were noted in care homes at points throughout the
13 pandemic.

14 As to the type of PPE supplied, we see records of
15 surgical masks, aprons, gloves and eye protection. No
16 sign of FFP3 masks, my Lady, so essential in preventing
17 aerosol transmission.

18 Again, the issue is best expressed in the words of
19 one of the group's members, Catherine Griffiths. Her
20 father contracted Covid in his care home in Aberystwyth.
21 She describes the last time she saw him:

22 "On 16 November 2020 I was invited to the care home
23 to say goodbye to Dad. I wanted to go in, sit by his
24 side and hold and comfort Dad. My brother urged me not
25 to. The level of PPE in the home was abysmal. We could

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1 Sam Smith-Higgins, the other co-leader of the group,
2 her father caught Covid in hospital in January 2021. He
3 was not permitted access to a HEPA filter, despite such
4 filters being low cost and portable, and nor was he ever
5 evidence offered a mask. He tragically passed away
6 three weeks after admission.

7 Finally, Sylvia, she appeared in the impact video in
8 Module 3, my Lady. She lost her father after he caught
9 Covid in a community hospital in April 2020. She saw
10 undertakers there in full hazmat suits. Healthcare
11 workers, reliant on supplies from the local health
12 board, had nothing.

13 The group's members feel a real sense of betrayal.
14 They did everything in their power to keep their loved
15 ones safe. They followed the Government guidelines
16 stringently, yet they could not keep their loved ones
17 safe in hospital, and the members of the group want to
18 know why was the risk of contracting Covid in hospital
19 so high? Many of them strongly believe that poor
20 prevention and infection control, including lack of
21 appropriate PPE, lack of access to oxygen and
22 ventilators, and poor ventilation, led to the death of
23 their loved ones.

24 Second point, care homes. My Lady, care homes in
25 Wales, particularly in the early stages, were completely

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1 see the nurse wearing just an apron and a flimsy
2 surgical mask. I was forced to say goodbye to my father
3 whilst standing in the icy rain outside his window."

4 The group is extremely concerned that Covid was left
5 to run rampant through care homes in Wales, leading to
6 an unacceptable loss of life, and they want to know why
7 was the use of PPE in care homes so patchy? Why was
8 supplies of PPE and appropriate PPE so lacking?

9 My Lady, my third and final point: infection
10 prevention and control, IPC guidance on FFP3 masks.

11 Wales went into the pandemic with 90% of its FFP3
12 masks out of date. A four nations meeting on 12 March
13 2020 dealing with shortages of FFP3 masks across the
14 nations flagged that Wales was in particular difficulty.
15 It had just 10,000 of them. To put that in some
16 context, that's just 10% of Northern Ireland's stock,
17 despite Wales having double the population.

18 From 13 March, one day later, IPC guidance was
19 announced that FFP3 masks were to be used only in
20 intensive care units and aerosol-generating procedures.
21 Professor Catherine Noakes, from whom you heard in
22 an earlier module, suggested that the reluctance to
23 properly acknowledge airborne transmission was in part
24 because, and I quote:

25 "... the significant resource and operational

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1 implications of doing so."

2 Was it the case that a shortage of supply improperly
3 dictated the terms of the IPC guidance? It was known
4 that the virus was spread by aerosol transmission from
5 the early stages of the pandemic. Suffice to quote
6 Professor Van-Tam, who said in January 2020 that:

7 "Historical HSE position is that maximum RPE is
8 required."

9 The group want to know why was this ignored? Why
10 did IPC guidance not reflect this?

11 The impact of IPC guidance was experienced directly
12 by some of the group's members. Sian Haigh, her
13 husband, Alan, was an emergency technician for the Welsh
14 Ambulance Service in Carmarthenshire. He caught Covid
15 by attending the home of a Covid patient. He was
16 wearing a surgical mask, apron and gloves. His
17 colleague had an FFP3 mask and a visor, as she was
18 administering treatment. Both acted in accordance with
19 IPC guidance. Sadly Mr Haigh's level of PPE was not
20 sufficient to protect him. He passed away and his
21 inquest concluded that the cause of death was industrial
22 accident due to not having an FFP3 mask.

23 So briefly to conclude, my Lady, as we've heard, the
24 Inquiry will hear evidence about the process of
25 procurement, supply chains, VIP Lanes, and so on, but at

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1 this chaos spread to procurement of the vital equipment
2 that people of our four nations needed so desperately to
3 keep us safe. Market forces dictated that timescales
4 were shortened, demand increased, suppliers were able to
5 choose who to sell to and for how much. The Scottish
6 Covid Bereaved asked: where was the accountability for
7 spending public money?

8 The processes and procedures that ought to have been
9 undertaken, the unglamorous, if necessary, paperwork was
10 not done. The bereaved consider that, without this
11 recording of information, there was no set criteria in
12 the awarding of contracts, and this led to a number
13 of -- with the use of significant understatement -- very
14 poor business decisions.

15 These had direct impact on the availability of
16 life-saving equipment and items in our hospitals, care
17 homes and communities. There has, of course, been great
18 focus on the high priority or VIP Lane. The bereaved
19 are anxious to know who thought this to be a good idea.

20 What, if any, consideration was given to
21 prioritising pre-existing companies who had track
22 records in meeting contracts and deadlines? Why was it
23 thought that the criteria of knowing people was somehow
24 the best defining factor of what would get us the best
25 PPE at the lowest prices?

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1 the end often the day, of course, procurement was
2 ultimately about people. The main purpose of
3 procurement was to save lives. For the members of the
4 group, procurement didn't save lives, and they, of
5 course, want to know why.

6 Thank you, my Lady.

7 **LADY HALLETT:** Thank you very much indeed, Ms Parsons.
8 Dr Mitchell.

9 **Submissions on behalf of the Scottish Covid Bereaved by**
10 **DR MITCHELL**

11 **DR MITCHELL:** I'm instructed by Aamer Anwar on behalf of the
12 Scottish Covid Bereaved -- *(microphone off)*

13 **LADY HALLETT:** I'm not sure it's working. Try again.

14 **DR MITCHELL:** Hello? Yes.

15 I am instructed by Aamer Anwar & Company on behalf
16 of the Scottish Covid Bereaved. Throughout this
17 Inquiry, the bereaved have discovered a great many
18 things that they suspected were indeed true: the country
19 was not ready for a pandemic; governments fell into
20 panic and chaos; systems and structures that should work
21 as checks and balances on power were swept aside for
22 a small group making unchecked and unaccountable
23 decisions. So it is we find that the same problems
24 affected the procurement of PPE.

25 From the material available so far, it appears that

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1 The disclosure made to Core Participants has brought
2 to light research showing that, on occasion, the High
3 Priority Lane only provided the most expensive average
4 price per unit for three categories: gloves, aprons and
5 body bags.

6 It was known that the companies involved with the
7 High Priority Lanes were mostly dealing with
8 intermediaries, many of whom were sourcing from the same
9 factories in China that the government was already in
10 contact with. It was known that this route was
11 potentially disruptive, rather than additive to the
12 process of getting PPE.

13 In addition, as aforementioned, the audit trails
14 which should have been at the very heart of government
15 procurement were not working. They were inconsistent
16 and limited. This clearly not acceptable.

17 The Scottish Covid Bereaved consider that, for some,
18 the pandemic was seen as an opportunity to defraud and
19 make obscene profit. The bereaved wish to know whether
20 profit was put before people. They wish to know what
21 can be done when the next pandemic comes to ensure that
22 the strict guidance in place to allow for proper
23 procurement processes will be there. It's only by doing
24 there is that the people of Scotland, and the rest of
25 the United Kingdom, can be sure that the interests of

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1 we, the people, are being placed before profit.
 2 These are the submissions of the Scottish Covid
 3 Bereaved.
 4 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell, I'm
 5 very grateful.
 6 Who is next? Mr Thomas?
 7 **Submissions on behalf of the Federation of Ethnic Minority**
 8 **Healthcare Organisations by PROFESSOR THOMAS KC**
 9 **PROFESSOR THOMAS:** My Lady.
 10 **LADY HALLETT:** Are you switched on?
 11 **PROFESSOR THOMAS:** My Lady, can you hear me?
 12 **LADY HALLETT:** Yes.
 13 Are you switched on, Mr Thomas?
 14 **PROFESSOR THOMAS:** I am.
 15 **LADY HALLETT:** Oh, you are now.
 16 **PROFESSOR THOMAS:** "The true measure of any society can be
 17 found in how it treats its most vulnerable members."
 18 Ghandi.
 19 My Lady, as we commence Module 5 of this Inquiry, we
 20 are presented with an opportunity to rigorously examine
 21 the procurement process during the Covid pandemic. We
 22 say that this module is crucial because it focuses on
 23 assessing whether these processes adequately consider
 24 and address the needs of the NHS diverse workforce and
 25 the communities they serve. There are also some key

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1 inequalities each and every day of the pandemic. They
 2 continue to do so and will continue to do so until real
 3 action is taken to ensure that society is equal, just
 4 and fair.
 5 Black, Asian and Minority Ethnic staff now make up
 6 almost a quarter of the workforce overall, 24.2%; more
 7 than two fifths, 42%, of doctors, dentists and
 8 consultants; and almost a third, 29.2%, of nurses,
 9 midwives and health visitors. Yet, representation at
 10 board level is only 13.2%.
 11 The figure for very senior managers is lagging at
 12 about 10.3%. This gross under-representation in
 13 decision making, including in procurement, has
 14 contributed to the disproportionate impact experienced
 15 by FEMHO's members. You see, my Lady, Module 5 provides
 16 a crucial opportunity to prevent future injustices and
 17 ensure that these disparities and the inequality and the
 18 equality duties designed specifically to minimise their
 19 impact and promote equality are never again forgotten or
 20 ignored within procurement processes in decision making.
 21 We submit that the disproportionate impact of the
 22 pandemic and, in particular, its impact on ethnic
 23 minority home workers, should never be sidelined or
 24 an afterthought.
 25 While we note that these issues were not addressed

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1 questions for the Inquiry to explore, on the involvement
 2 and representation of Black, Asian and Minority Ethnic
 3 people in leadership roles, and decision making in the
 4 procurement processes.
 5 We urge you and your team to scrutinise how measures
 6 implemented during the pandemic ensured that the
 7 procurement practice and processes were not only
 8 efficient but also equitable.
 9 Our discussion today is particularly centred on
 10 understanding the impact of these practices and
 11 processes on Black, Asian and Minority Ethnic healthcare
 12 and social care workers who were disproportionately
 13 affected by the pandemic.
 14 My Lady, we have said it before and it does bear
 15 repeating: the first ten doctors to die and lose their
 16 lives to the virus were from the Black, Asian and
 17 Minority Ethnic backgrounds. That these deaths were of
 18 Black, Asian and Minority Ethnic doctors, was not
 19 a coincidence.
 20 These tragic losses, representing not just
 21 colleagues but also friends and family, underscored the
 22 dire consequences of structural and systemic
 23 inequalities deeply rooted in our society. FEMHO's
 24 members, who stand at the intersection of race and
 25 healthcare, lived the reality of structural and systemic

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1 in Counsel to the Inquiry's opening statement, we trust
 2 that the Inquiry will address these issues as we proceed
 3 in Module 5.
 4 FEMHO considers that Module 5 examines how
 5 government procurement processes and procedures and
 6 decision making differentially affected ethnic minority
 7 communities and there are number of things that we'd ask
 8 you to look at. Firstly, we acknowledge this Inquiry's
 9 commitment to exploring these disparities but we urge
 10 you, my Lady, to ensure that these important topics are
 11 kept at the forefront of everything the Inquiry does,
 12 including now, within your assessment of procurement
 13 processes.
 14 So what are the essential questions? My Lady, there
 15 are some important questions for your consideration.
 16 When you examine procurement strategies implemented
 17 during the pandemic, we invite you to ask the following:
 18 how? How were these strategies designed to reflect the
 19 needs of the NHS's diverse workforce?
 20 Were considerations of diversity integral to the
 21 procurement process from the outset?
 22 Were the procurement strategies in place
 23 sufficiently robust to address the urgent needs of all
 24 healthcare workers, particularly those from Black, Asian
 25 and Minority Ethnic backgrounds who faced

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1 disproportionate risks.
2 What evidence was gathered to show that the measures
3 taken during the procurement processes were effective in
4 preventing losses of healthcare workers, especially
5 amongst ethnic minorities?

6 Where? Where did these measures fall short and why?

7 Then turning to the long-term consequences of the
8 procurement decisions, in the light of the acknowledged
9 structural inequalities, the following questions may be
10 relevant:

11 How did the decisions made during the pandemic
12 affect long-term resilience and equity within the NHS?

13 What steps are now required to rectify these
14 disparities?

15 How did the NHS and the government bodies ensure
16 that compliance with the Public Sector Equality Duty
17 during the procurement processes, if at all?

18 Were any compliance measures effectively monitored
19 and enforced?

20 So my Lady, as ever, FEMHO is here to assist you and
21 the Inquiry in ensuring that the mistakes of the
22 pandemic are not repeated and that the reforms we pursue
23 are bold, inclusive, and lasting. FEMHO wishes to
24 assist you in this with solutions. I've always said
25 this: we want to be solutions orientated. So FEMHO is

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1 unsafe for all, both physically and psychologically.
2 Minority ethnic healthcare workers were more likely to
3 work in hazardous conditions, without adequate RPE or
4 PPE, than white counterparts. Not only this, they were
5 the least empowered to speak up about it, and you've
6 heard evidence about that in previous modules.

7 So FEMHO submits that the dire circumstances that
8 they faced and were labouring under, and which their
9 patients and service users were also expected to endure,
10 can be traced back to a highly flawed procurement
11 process and decision making. Never mind having regard
12 to due regard, these processes and decision making
13 appear to have taken no account at all of the Public
14 Sector Equality Duty. No account appears at all to have
15 been taken about the disparate impact, which was
16 obvious, and you've heard evidence about that in
17 previous modules.

18 We also contend that the structural inequalities
19 shape the availability and indeed access to the lateral
20 flow tests and PCR tests and, as we've previously
21 stated, this Inquiry has the profound responsibility to
22 confront what we describe as uncomfortable truths of
23 systemic inequality and structural.

24 These are not peripheral issues to the pandemic
25 response, they are central failings that cost lives.

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1 of the view that structural inequalities impacted upon
2 the procurement decisions, the availability of
3 healthcare equipment and supplies during the pandemic,
4 leading to significant shortages of the very equipment
5 that health and social care workers and their patients
6 desperately needed.

7 There is no doubt that PPE was in short supply,
8 we've heard that, and, even when it was available, it
9 was not suitable or effective for some Black, Asian and
10 Minority Ethnic people. Much of the typical PPE
11 procured in the UK has been designed and manufactured
12 based on the average facial measurements of a white man.
13 We've heard that already, and this is just simply
14 unacceptable in today's society.

15 Powered air purifying respirator hoods, which were
16 not required to be close fitting, were not supplied and,
17 even if it appears that the cost differential between
18 this and other PPE was not significant, there was also
19 too few ventilators and not enough oxygen.

20 So let me summarise by just saying this and
21 finishing by saying this: in the circumstances of the
22 pandemic, this was all life-saving equipment which, if
23 not available, quite obviously led to avoidable deaths.
24 The circumstances which health and social care workers
25 faced in the workplace during the pandemic was patently

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1 So, my Lady, we urge this Inquiry to keep these
2 issues at the forefront of its investigation into
3 procurement. Let's ensure that the findings from this
4 Inquiry lead directly to substantial reforms making our
5 healthcare system a fair and safe place for every
6 community it serves.

7 Thank you, my Lady.

8 **LADY HALLETT:** Thank you very much indeed, Mr Thomas.
9 Mr Stanton.

10 **Submissions on behalf of the British Medical Association by**
11 **MR STANTON**

12 **MR STANTON:** Thank you, my Lady.

13 The opening statement on behalf of the British
14 Medical Association is as follows. Poor procurement and
15 distribution of vital healthcare equipment and supplies
16 meant that healthcare staff had to care for their
17 patients with scarce resources, inadequate equipment,
18 and the ever-present danger of a potentially deadly
19 virus, often without the protection they so desperately
20 needed.

21 This had a devastating and lasting impact on staff
22 and patients alike, causing stress anxiety,
23 moral injury, infection, long-term disease, and sadly,
24 death.

25 This statement covers the procurement, distribution

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1 and the experience of the end user in relation to PPE,
2 testing, ventilators, and oxygen.

3 First, PPE. The quantity and quality of PPE
4 supplies was woefully inadequate, with over four in five
5 respondents to a BMA survey stating that they did not
6 feel fully protected during the first wave. There was
7 severe shortages of PPE across all healthcare settings,
8 particularly in the early months. Healthcare staff were
9 forced to go without PPE, reuse single use items, and
10 use handmade or self-bought items.

11 One GP in Northern Ireland told the BMA: "We were
12 sent six pairs of gloves and six aprons in an envelope
13 approximately three weeks after the start of lockdown."

14 Some Inquiry witnesses have stated that the UK never
15 ran out of PPE and that the problems were with the
16 distribution rather than overall quantities. It will be
17 important for the Inquiry to fully explore both of these
18 issues, and yet the bottom line remains that healthcare
19 staff did not have access to the life-saving PPE they
20 needed when they needed it.

21 In some cases, PPE was defective and failed to meet
22 safety requirements. Some of these faulty items reached
23 frontline staff, with numerous reports of face mask
24 straps breaking. Ultimately, billions of pounds' worth
25 of PPE arrived unfit for purpose and had to be

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1 Alongside this, the UK's ability to supplement PPE
2 stockpiles in times of crisis was compromised by
3 a reliance on just-in-time contracts and a lack of
4 domestic manufacturing capacity.

5 Second, there was a failure to procure adequate and
6 appropriate PPE as a direct result of flawed infection
7 prevention and control guidance, which failed to
8 recommend adequate protection against aerosol
9 transmission, despite longstanding scientific
10 understanding of the level of protection required in
11 these circumstances.

12 This failure was influenced by the critical shortage
13 of respiratory protective equipment in early 2020.
14 Further, once the IPC cell recommended that respiratory
15 protective equipment was not required for routine care
16 of Covid-19 patients, it stubbornly refused to revise
17 its position later in 2020 when there was increasingly
18 strong evidence for aerosol transmission and at a time
19 when the easing of supply constraints would have made it
20 possible to procure the necessary quantities of
21 respiratory protection but for the limitations imposed
22 by the guidance.

23 These mutually reinforcing influences, the initial
24 shortages which led to flawed guidance, followed by the
25 stubborn refusal to change the flawed guidance, worked

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1 destroyed.

2 Many BMA members reported feeling pressured to work
3 without adequate protection. They lived in constant
4 fear for their own lives, and the lives of their
5 patients, colleagues and loved ones.

6 Many healthcare workers, including over 50 doctors,
7 tragically died, and it cannot be emphasised enough that
8 these deaths were not inevitable.

9 Large numbers of staff developed Long Covid and they
10 continued to experience the devastating personal and
11 professional effects, with many unable to work or train,
12 losing their careers and livelihoods as well as their
13 health.

14 Adverse impacts were also disproportionately
15 experienced by women, ethnic minority staff, and those
16 with a disability or long-term health condition.

17 There are many factors that contributed to these
18 failings, but for present purposes, the BMA highlights
19 just three of the main causes. First, pandemic planning
20 for PPE was inadequate. The focus on pandemic influenza
21 rather than preparing for a wider range of threats meant
22 that the stockpiles were primarily comprised of
23 fluid-resistant surgical masks rather than respiratory
24 protective equipment which protect from aerosol
25 transmission.

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1 together to leave staff unprotected throughout the
2 pandemic.

3 Third, the failure of government leaders to act
4 quickly to secure adequate stocks of PPE, including the
5 failure to participate in the joint EU procurement
6 scheme, and processes that were characterised by delay,
7 lack of transparency, and a lack of due diligence,
8 notably in the use of the High Priority Lane.

9 At a time when frontline staff had been risking
10 their lives working in an under-resourced and unsafe
11 system, BMA members felt particularly let down by
12 reports of these failures and the significant amounts of
13 money wasted.

14 Staff safety was also affected by lack of access to
15 testing. The initial limited capacity to test at the
16 scale needed, combined with shortages of tests
17 themselves, and the UK Government making relatively
18 little use of the pre-existing NHS laboratories, caused
19 delays in identifying cases and likely meant that staff
20 unwittingly transmitted Covid-19 to patients and
21 colleagues. It also impacted staff capacity at this
22 critical time due to self-isolation.

23 Turning to ventilators. Procurement processes for
24 this equipment were inefficient and inadequate, and
25 resulted in the provision of ventilators that were

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1 unsafe, unsuitable and unfamiliar to staff, which led to
2 the need to transfer patients to different hospitals due
3 to a lack of critical care capacity.

4 Time and money were also wasted on new ventilator
5 prototypes which were never ultimately purchased,
6 despite the fact that there were ventilator models that
7 were already approved by the MHRA.

8 All of this led to localised shortages of
9 ventilators, especially in London during March 2020, in
10 response to which anesthesia machines, which are only
11 designed to be used for a few hours at a time, were
12 repurposed and used as substitutes for ventilators.

13 The necessity of this measure highlights the
14 critical gap in capacity at the height of the first
15 wave.

16 Such shortages also had significant impacts. They
17 affected patient care, and they also exacerbated the
18 atmosphere of stress and uncertainty for staff at an
19 already incredibly challenging time.

20 In respect of oxygen, the pandemic exposed
21 significant vulnerabilities in the UK's medical oxygen
22 supplies to hospital wards, which had never been
23 subjected to the strain they were under during the peaks
24 of the pandemic in 2020 and 2021.

25 The risk of a sudden loss of oxygen pressure within
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1 the physical and mental health of healthcare staff, and
2 the lack of transparency, robustness and value for money
3 has damaged their trust and confidence in the systems
4 that should have protected them and their patients.

5 Trust will not return easily, and the Inquiry's
6 recommendations in this module will be a vital part of
7 the journey to rebuild it.

8 The BMA respectfully requests that the Inquiry
9 focuses on issues and evidence that will, first, lead to
10 better protection for healthcare staff, including
11 through a reliable, diverse supply of PPE available to
12 suit all staff and for a range of potential pathogens.

13 Second, improved patient care and reduce staff moral
14 injury through better supplies of key equipment, such as
15 ventilators, and the ability of NHS estates to supply
16 oxygen at scale in future emergencies.

17 Third, reform procurement and outsourcing processes
18 to ensure greater transparency, efficiency, and
19 accountability.

20 And finally, fourth, increase domestic manufacturing
21 capacity for PPE and other key healthcare supplies.

22 Thank you, my Lady.

23 **LADY HALLETT:** Thank you very much indeed, Mr Stanton.
24 Mr Smith.

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1 hospital oxygen delivery systems was a major concern,
2 and to reduce the risk of this happening, delivery flows
3 were maximised and staff were told to ration oxygen by
4 reducing target oxygen saturation levels in patients,
5 which contributed to stress and moral injury.

6 One resident doctor in England told the BMA that:
7 [As read] "It was mostly luck that our oxygen
8 supplies did not fail."

9 This highlights an important structural issue: aged
10 hospital estates are a key strain on oxygen levels and
11 it is crucial that hospital estates are upgraded to
12 ensure they can deliver high-flow piped oxygen when the
13 next pandemic hits, so that this life-saving resource is
14 readily accessible at the levels required when needed
15 most.

16 My Lady, in conclusion, millions of pounds of public
17 money were wasted through rushed and ill-thought-through
18 procurement during the pandemic, including PPE that
19 never reached healthcare staff and ventilators that
20 never reached patients.

21 Procurement and distribution of healthcare equipment
22 are not just bureaucratic processes, they are a lifeline
23 that provide critical protections and supplies to ensure
24 the safety of those who work in the system and those
25 that they care for. The failure to do this has impacted
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1 **Submissions on behalf of UK Anti-Corruption Coalition**
2 **by MR SMITH**

3 **MR SMITH:** My Lady. Thank you for giving the
4 UK Anti-Corruption Coalition the opportunity to speak
5 today.

6 I am Chris Smith, the Public Procurement Consultant
7 and member of the Chartered Institute of Procurement
8 Supply who, among many other procurement projects over
9 four decades, procured PPE for the UK-funded Ebola
10 treatment centres in Sierra Leone in 2014.

11 We have submitted a 180-plus-page Rule 9 response to
12 the Inquiry, which includes eight lessons learned and
13 recommendations for the Inquiry to consider, and have
14 been invited to give evidence tomorrow, for which we are
15 very grateful.

16 One of our members, Transparency International,
17 recently published a report, *Behind the Masks --*
18 *Corruption Red Flags in Covid-19 Public Procurement*,
19 which we have already shared with the Inquiry.

20 My Lady, the UKACC speaks truth to power, and we
21 hope the work we are doing to support the Inquiry will
22 help to get power to speak the truth, no matter how
23 uncomfortable that truth may be, because, by doing that,
24 we are convinced valuable lessons will be learned and
25 future lives saved.

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1 On 20 March 2020, Gavin Hayman of the Open
2 Contracting Partnership, a member of UKACC, published
3 an article entitled *Emergency procurement for Covid-19:*
4 *Buying fast, open and smart*, with a number of
5 constructive and practical suggestions.

6 Vaccine procurement is widely considered to have
7 been a huge success story, a miracle, a life saver. In
8 contrast, the public and media perception is that the
9 PPE procurement wasn't open or smart and the words
10 "profiteering", "cronyism", "incompetence", "vested
11 interests", "secretive", "corrupt", "ineffective",
12 "hugely wasteful" and even "cover-up" are more likely to
13 spring to mind in the public consciousness.

14 Foremost in our minds in applying to become Core
15 Participants was our collective belief that lives were
16 unnecessarily put at risk and lost, and taxpayers' money
17 wasted, on a colossal scale because of the approach the
18 UK took to the purchase of PPE.

19 In the spectrum of items procured by government,
20 from atomic bombs to zero emission buses, we say that
21 PPE should not be a difficult category to buy properly.
22 We note the NHS was procuring large amounts of PPE
23 before the pandemic for its day-to-day needs, and the
24 PPE requirements, such as masks, aprons and gloves, were
25 straightforward and not, unlike Covid-19, novel.

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1 Supply Chain Coordination Limited has never published
2 many PPE contracts worth billions of pounds, and most
3 others issued by DHSC have only been partially
4 published, a clear breach of Cabinet Office transparency
5 policy.

6 We have concluded that this is due to a toxic mix of
7 bad recordkeeping, indifference, defensiveness of the
8 organisations concerned. We also surmise that, in some
9 cases, contracts don't even exist, which, if true, is
10 worthy of further investigation by the Inquiry.

11 We would like to reiterate our serious concern that
12 the procurement of some £10 billion worth of Covid
13 related services contracts, many also awarded without
14 competition, remains out of scope for Module 5. Whilst
15 we welcome the inclusion of procurement case studies, we
16 are very concerned, like other CPs, that no suppliers of
17 PPE have been asked to give evidence. We feel strongly
18 that, whilst the government side of procurement is
19 important to scrutinise, in order to get to the bottom
20 of what went wrong, the Inquiry must have evidence in
21 front of it from the supplier side because, to put it
22 frankly, we believe in many cases serious mistakes were
23 made by Government that may have led to incorrect
24 supplies of PPE.

25 For example, many government PPE contracts lacked

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1 Yes, during the pandemic the prices may be high, and
2 yes, the availability may be a severe constraint, but
3 following standard, best practice procurement principles
4 and techniques, if it should have been possible to avoid
5 many of the problems that arose: incorrect supply,
6 non-compliant packaging, numerous contractual disputes,
7 and a massive write off of taxpayers money.

8 It seems reasonable to assume that such problems
9 impacted the availability of PPE in the healthcare
10 settings and care homes with, in some cases, tragic
11 consequences. We say that the government's outsourcing
12 of PPE sourcing to British traders, who, in some cases,
13 had no prior experience supplying PPE, or in some cases
14 no prior existence, was a reckless strategy that should
15 at least have been mitigated by payment conditional on
16 a pre-shipment inspection. This pre-shipment inspection
17 never happened and many of the quality problems were
18 only discovered after the PPE arrived in the UK and the
19 supplier paid in full. This approach increased the
20 shortages of useful PPE and posed a substantial fiscal
21 risk which materialised.

22 We say there is a continued lack of transparency
23 concerning Covid contracts. The government failed and
24 continues to fail to meet its transparency obligations
25 by publishing copies of all PPE contracts in full.

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1 proper technical specification, which increased the risk
2 of an incorrect supply. High Court documents, in the
3 public domain for the PPE Medpro contract suggest this
4 is a real possibility. The evidence from both parties
5 in that case is conflicting and revealing because the
6 PPE supplier has given evidence, raising questions of
7 government competence that we fear will not necessarily
8 be discovered if the Inquiry in its own investigation
9 only relies on the Government's account of how it
10 responded to suppliers offering PPE.

11 The decision appears inconsistent with the Inquiry's
12 approach to ventilator contracts, where suppliers have
13 been asked to give evidence and, to some extent,
14 provides the central government's debts and ex-ministers
15 and officials with an opportunity to mark their own
16 homework.

17 As Core Participants, we express serious concerns
18 and dismay about the government's repeated delays in
19 providing vital evidence to the Inquiry, which was
20 discussed during the second preliminary hearing. These
21 delays must have impacted significantly the Inquiry's
22 ability to conduct a comprehensive investigation into
23 procurement practices during the pandemic, undermined
24 its effectiveness and the public's right to full
25 accountability and transparency.

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1 This unacceptable situation is particularly
2 concerning, considering that Prime Minister Keir Starmer
3 said in July 2024 that "The safety and security of the
4 country must always be the first priority, and this
5 government is committed to learning lessons from the
6 Inquiry and putting better measures in place to protect
7 and prepare us for the impact of any future pandemic".

8 We are concerned that the interests of central
9 government departments in this case is their first
10 priority and we find their excuses unconvincing and
11 concerning. We appreciate your Ladyship's continued
12 efforts to obtain all the requested evidence.

13 The Inquiry's findings and recommendations are
14 crucial to ensure that lessons are learned and
15 government departments implement safeguards to prevent
16 the misuse of public funds and poor procurement that put
17 lives at risk in future emergencies. We say that the
18 Government and Department of Health and Social Care in
19 particular must demonstrate commitment to transparency
20 and accountability by fully cooperating with the Inquiry
21 without further delay. We call on the Secretary of
22 State for Health and Social Care to make sure this
23 happens. The Inquiry and the public, particularly the
24 bereaved families, deserve a full and transparent
25 account of all decisions made during the pandemic.

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1 PPE, who in some cases exploited the situation, took
2 advantage of the Government and NHS's vulnerable
3 position and profiteered at the taxpayers' expense,
4 whilst in some cases also failing to deliver usable PPE.

5 As a result, the NHS was not fully protected, nor
6 was a loss of life minimised. Such behaviour was
7 shameful and those mainly British companies let the
8 country down in its hour of need and, again, we question
9 why only one PPE contract has been the subject of High
10 Court action.

11 Last week the deputy Prime Minister, Angela Rayner,
12 announced that the Government was investigating under
13 new powers available to it in the Procurement Act
14 a number of suppliers involved in the refurbishment of
15 Grenfell Tower with a view to possible debarment from
16 involvement in future public contracts. We call on the
17 Government not to wait for your report and to launch
18 similar investigations into certain suppliers of PPE
19 now.

20 In conclusion, we pay tribute to the work of the
21 Good Law Project, certain parts of the media,
22 independent journalists, MPs and Members of the House of
23 Lords who worked tirelessly to hold the Government
24 accountable and exposed many of the issues of concern
25 about if it is approach to procuring PPE to the public

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1 The VIP Lane was created by politicians who went far
2 beyond the call of duty to help, and strayed into
3 dangerous territory and, in some cases, introduced
4 significant additional risks for the NHS, healthcare
5 workers, patients and taxpayers that materialised.

6 In opposition, the current government tabled several
7 amendments to the draft Procurement Bill to outlaw VIP
8 Lanes. These amendments were rejected and have not been
9 addressed by the current government in regulations or
10 guidance and the risk of some future government
11 resorting to VIP Lanes during some further crisis
12 remains something we hope the Inquiry will consider.

13 However, we ask the Government not to wait for your
14 report and publish regulations or guidance prohibiting
15 the use of the VIP Lanes. In opposition, the Labour
16 Party committed to follow Ukraine's footsteps and
17 publish an accessible dashboard of government contracts
18 that is available to anyone as part of our public works
19 pledge. The central digital platform is not sufficient
20 and we call upon the Cabinet Office to establish
21 citizen-friendly dashboards, so that we can monitor
22 public contracts, including emergency contracts, during
23 any future crisis.

24 We note the stark contrast between AstraZeneca,
25 which sold its vaccine at cost, and British suppliers of

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1 and to the Inquiry's scrutiny.

2 Lives were, without doubt, lost due to very bad and
3 reckless procurement decisions made by the Government,
4 and unscrupulous and greedy suppliers, and we urge the
5 Inquiry to leave no stone unturned to help ensure this
6 never happens again. The families of the bereaved and
7 the wider public deserve nothing less.

8 The pandemic was unavoidable but the sometimes
9 chaotic and ineffective maladministration of the
10 procurement of some PPE most certainly was. We are at
11 your disposal for any clarification or any additional
12 information that you or your team require.

13 Thank you.

14 **LADY HALLETT:** Thank you, Mr Smith.

15 Mr Mitchell.

16 **Submissions on behalf of the Scottish Ministers**
17 **by MR MITCHELL KC**

18 **MR MITCHELL:** My Lady, this is the opening statement on
19 behalf of the Scottish Government. I appear today along
20 with junior counsel Michael Way, and we are instructed
21 by Caroline Beattie and Callum McCue of the Scottish
22 Government Legal Directorate.

23 During the pandemic, the environment in which
24 procurement agencies found themselves operating was
25 unprecedented, as, around the globe, nations rushed to

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1 secure the materials necessary to protect their
2 citizens. This context is important in arriving at
3 a proper understanding of the response to the challenges
4 faced. In Scotland, however, remarkable outcomes were
5 achieved.

6 In large part this was due to robust, tried and
7 tested public procurement processes, networks and
8 relationships that had existed prior to the pandemic.

9 In these regards, Scotland began from a strong
10 starting point, yet that was not the only reason for the
11 positive outcomes. The Scottish Government sought to
12 develop new relationships and to innovate. In this
13 opening statement, therefore, our themes are
14 collaboration, relationships, innovation, and
15 governance.

16 These were the keystones of the approach adopted by
17 the Scottish Government.

18 Looking firstly at some key structures and
19 processes. The Scottish Government Procurement and
20 Property Directorate is responsible for developing and
21 maintaining a framework of Scottish public procurement
22 legislation and policy. A significant procurement
23 reform programme begun in 2006 had brought about
24 a familiarity with policy and with legislation. This
25 led to established connections with technical and

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1 Government ICU Resilience and Support Group. This group
2 provided central co-ordination and made key decisions on
3 the distribution of equipment to NHS boards.

4 The Scottish Government entirely recognises the need
5 to engage and to work closely with partners across
6 the UK. It did and it will continue to do this.
7 However, given the expertise and the knowledge possessed
8 by NSS of Scottish requirements, the Scottish Government
9 is yet to be persuaded that the delegation of emergency
10 procurement to a four nations body would bring about
11 tangible improvements.

12 Turning now to governance, transparency, and
13 accountability. The Scottish Government relied upon the
14 pre-existing policies, the legislative framework, and
15 robust due-diligence checks to ensure good governance
16 and transparency.

17 The requirement to secure value for money was
18 emphasised in policy notes. The normal rules about
19 recordkeeping, guarding against conflict of interest,
20 continue to apply throughout the pandemic. The use of
21 emergency provisions within existing legislation was
22 necessary, and contributed to the speed at which the
23 Scottish Government and NSS could implement their
24 response.

25 A framework contract was awarded by the Scottish

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1 clinical experts, and with end users of products.

2 Actual procurement and distribution of PPE and
3 healthcare equipment is delegated to a special health
4 board, NSS. It has proven procedures in place for due
5 diligence, pricing, quality control, distribution, and
6 supply. It has longstanding, trusted relationships with
7 a diverse range of suppliers.

8 Prior to the pandemic, Scotland owned a PPE
9 stockpile, which was a vital part of the Scottish
10 Government's initial response to the pandemic. Although
11 supplies were stretched in their early months, at no
12 point did Scotland run out of PPE.

13 In April of 2020 the newly established Scottish
14 Government PPE Directorate led on the publication of the
15 PPE Action Plan. This aimed to ensure that the
16 right PPE of the right quality gets to the people who
17 need it at the right time.

18 It set out the roles and responsibilities at
19 a national level for procurement and distribution, as
20 well as the governance arrangements with the Scottish
21 Government. The PPE Strategy and Governance Board was
22 responsible for overseeing the implementation of the
23 action plan.

24 During the pandemic, procurement of ICU equipment
25 was undertaken by NSS in collaboration with the Scottish

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1 Government to Lyreco, an existing and trusted supplier,
2 to supply PPE to non-health or social care essential
3 services where they were struggling to access it.
4 Lyreco agreed to supply PPE at a cost basis, making the
5 contract good value for money.

6 In respect of any approach, bid or contact by the
7 Scottish Procurement Property Directorate, there have
8 been no suspicions, concerns, or instances of fraud in
9 relation to procurement or award of contracts before,
10 during or after the pandemic. In addition, no conflicts
11 of interest by civil servants or ministers are
12 identified in the contracts managed by the Scottish
13 Government, relevant to the scope often Module 5.

14 Audit Scotland carried out an assessment of the
15 arrangements in place at the Scottish Government to
16 prevent fraud and corruption. Audit Scotland concluded
17 that the Scottish Government had applied the appropriate
18 controls regarding new or extended Covid-19 procurement
19 contracts.

20 Looking now at the generation and the processing of
21 supply offers. From early in the pandemic, many offers
22 were received from potential suppliers in relation to
23 PPE. Initially, offers were received via a dedicated
24 mailbox and they were then triaged. Scottish Enterprise
25 and Scottish Development International carried out

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1 significant due-diligence checks, such as visiting
2 factories, including those based in China and the
3 Far East. In about mid-April of 2020, an online
4 supplier offer portal was created by NSS to automate and
5 streamline the triage process. Thereafter, NSS applied
6 its established procedures.

7 Approximately 2,700 offers were received, although
8 only one progressed to securing a contract from NSS.

9 As Mr Wald pointed out this morning, there was no
10 comparable system to the VIP or High Priority Lane in
11 Scotland. As far as the Scottish Government is aware,
12 no individual or company received preferential treatment
13 and procurement or the award of contracts.

14 Turning to emergency trade and strategy. At the
15 start of the pandemic, a key issue was that items were
16 either not produced in Scotland or at the scale needed.
17 A strategy was developed that comprised two parts:
18 firstly, a buy strategy, focused on securing supplies
19 rapidly in the global market; and, secondly, a make
20 strategy, focused on building supply capacity within
21 Scotland's manufacturing base. A major focus was on
22 identifying and working with Scottish manufacturers in
23 the production of key healthcare products. The make
24 strategy help to establish several new domestic supply
25 chains and support greater self-sufficiency.

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1 Further, between April and August 2020, the Cabinet
2 Secretary for Health and Sport, Ms Freeman, received
3 daily and weekly reports on the status of PPE and its
4 distribution.

5 Notwithstanding Scotland's geography and higher
6 proportion of remote settlements, NSS never reached
7 a point where distribution became entirely
8 overstretched.

9 My Lady, in conclusion, there's more that I could
10 mention, such as the work done by the Scottish
11 Government to identify the lessons to be learned, the
12 potential need for a mechanism to request emergency or
13 additional funding from the UK Government, over and
14 above that generated through the Barnett formula, and on
15 the good uses to which excess stock was put within
16 Scotland.

17 But time does not permit. These are important
18 topics and we would encourage those interested to read
19 our written opening statement, which will be available
20 on the Inquiry website.

21 As we hope we have shown in this opening statement,
22 the existence of working relationships, innovative
23 approaches, and tried and tested processes, were central
24 to the Scottish Government's approach to procurement
25 during the pandemic.

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1 By April 2021, around 88 per cent of Scotland's PPE
2 by volume, excluding gloves, was being manufactured
3 domestically. This was a considerable success.

4 Looking finally at distribution and logistics. In
5 April 2020, the Scottish Government's PPE Directorate
6 assisted in the co-ordination of a range of PPE delivery
7 aspects, including supply to GPs, dentists and social
8 care providers.

9 Prior to the pandemic, care homes procured their own
10 PPE. However, early on in the pandemic, the Scottish
11 Government worked with NSS to establish local PPE hubs.
12 In due course, these hubs supported the whole Social
13 Care Sector with all its PPE needs, where normal supply
14 routes had failed. The hubs also supported unpaid
15 carers and social care personal assistants. In
16 mid-April 2020, the Scottish Government announced that
17 NSS would provide a under-off top-up of supplies to all
18 care homes.

19 From 1 April 2020, frontline staff could raise any
20 issues with the quantity or quality of PPE via
21 a dedicated mailbox. At the same time, health boards
22 established a nominated single point of contact. These
23 individuals were people who were responsible for
24 managing PPE supply within their health boards, and they
25 were in place to resolve issues with supply concerns.

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1 All these contributed to a system that was
2 efficient, effective and fair.

3 In closing, the Scottish Government would wish to
4 pay tribute to all its partners with whom it worked and
5 collaborated in providing essential supplies and
6 equipment to keep the people of Scotland safe.

7 Thank you.

8 **LADY HALLETT:** Thank you very much, Mr Mitchell. We'll
9 break now. I shall return at 3.30.

10 (3.15 pm)

(A short break)

12 (3.30 pm)

13 **LADY HALLETT:** Ms Doherty, there you are.

14 **MS DOHERTY:** *(Microphone off)*

15 **LADY HALLETT:** I can hear you but you're not on the
16 microphone.

17 **MS DOHERTY:** That's it now.

18 **LADY HALLETT:** That's it.

19 **Submissions on behalf of NHS National Services Scotland**
20 **by MS DOHERTY KC**

21 **MS DOHERTY:** My Lady, I appear on behalf of NHS National
22 Services Scotland, or NSS for short. A written opening
23 statement for NSS has been provided to the Inquiry but
24 I will not repeat that whole statement today. Instead,
25 I would like to take the opportunity to focus on three

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1 matters: first, NSS's national procurement systems,
2 distinct from the other three nations in the UK; second,
3 National Procurement's cooperation with other three
4 nations in the UK; and, third, levels of PPE in Scotland
5 during the pandemic.

6 So the first point, my Lady, national procurement
7 systems distinct from the other three nations in the UK.
8 NSS provides national strategic support services and
9 expert advice to Scotland's NHS. For the purposes of
10 this module, the services provided by NSS's National
11 Procurement Directorate, National Procurement, for
12 short, are particularly relevant.

13 Consistent with healthcare in Scotland being
14 distinct from the rest of the UK, the systems operated
15 by National Procurement for obtaining healthcare related
16 equipment and supplies for NHS Scotland are also
17 distinct from those elsewhere in the UK. NSS is
18 accountable to the Scottish Government for procurement
19 and distribution of healthcare required equipment and
20 supplies to NHS Scotland boards by National Procurement.

21 So there's a Scottish NSS, a Scottish procurement
22 unit, which provides essential procurement and
23 distribution service to the Scottish NHS, and the
24 Scottish Government with overall responsibility, and
25 I stress the self-standing nature of the Scottish

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1 manage the surge in offers to supply products.
2 Contracts with new suppliers were subject to the
3 Scottish Government's requirement for supplier
4 validation, prior to offers being approved for purchase.

5 It's important to note, as has already been said by
6 others today, that the High Priority Lane or VIP Lane
7 established by the UK Government, did not exist in
8 Scotland and National Procurement had no involvement in
9 it.

10 I note that the Inquiry's expert, Professor
11 Sanchez-Graells, has noted with approval in his report
12 that Scotland and the other devolved nations were able
13 to continue, with limited adaptations, with their
14 existing organisational arrangements and processes for
15 healthcare procurement which facilitated oversight, and
16 he contrasts the position in England, where a new set of
17 arrangements was introduced.

18 My second point, my Lady, relates to National
19 Procurement's cooperation with the other three nations
20 of the UK. National Procurement collaborated with the
21 four nations' PPE working groups to support mutual aid,
22 and to ensure that there was no detrimental effect to
23 the supplies to the other UK nations from its
24 procurement for Scotland.

25 My third point, my Lady, relates to levels of PPE in

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1 position.

2 Prior to the pandemic, National Procurement had in
3 place an established and experienced procurement team
4 which worked closely with the procurement colleagues
5 across the Scottish health boards. It had established
6 networks across the NHS and Scotland, and with key
7 suppliers of healthcare equipment and supplies.

8 When the NHS in Scotland was placed into emergency
9 measures at the start of the pandemic, the Scottish
10 Government established a dedicated PPE team. As
11 a delivery partner of the Scottish Government, National
12 Procurement purchased, stored and distributed PE stock
13 during the pandemic. Its established procurement team
14 and pre-existing networks proved to be of great benefit
15 in these tasks.

16 Relying on its existing systems and knowledge, it
17 was able to procure high volumes of PPE and other key
18 equipment. Prices were volatile, which meant National
19 Procurement had to purchase in a complex and uncertain
20 market. It was able, however, to obtain most products
21 at prices commensurate with the prevailing market
22 conditions, as noted by Audit Scotland in its Covid-19
23 PPE report. National Procurement relied on its
24 existing, trusted suppliers where possible.

25 A supply offers portal was set up to receive and

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1 Scotland during the pandemic. At no point during the
2 pandemic did National Procurement's stockpile of PPE for
3 NHS Scotland run out. Throughout this period, incoming
4 stock arrived at the central national distribution
5 warehouse and was distributed.

6 The fact that the national stockpile did not ever
7 run out was confirmed by Audit Scotland in its Covid-19
8 PPE report.

9 To aid oversight of stock levels at a local NHS
10 level, NSS introduced a daily stock count in hospitals,
11 and later introduced a national inventory management
12 system across NHS Scotland health boards to support
13 pandemic stock availability and management.

14 Also of note is that from March 2020, National
15 Procurement's role to support NHS Scotland's health
16 boards was expanded to include supporting Scotland's
17 primary healthcare and social care sectors.

18 In conclusion, my Lady, National Procurement's
19 priority during the pandemic was to protect frontline
20 services, staff, carers, patients and residents across
21 health and social care. Its staff recognise that
22 securing an immediate, high-volume supply of PPE and
23 other key healthcare products was of critical importance
24 in meeting that priority.

25 National Procurement staff responded to the

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1 challenge in a professional and efficient manner,
2 thereby supporting Scotland's response to the pandemic.

3 Witnesses to procurement and distribution in
4 Scotland are due to give evidence on Monday, 24 March.
5 Given the distinct nature of Scotland's procurement
6 services compared to those elsewhere in the UK, it is
7 hoped that other witnesses who give evidence in this
8 module make clear the geographical extent of the
9 procurement services about which they give evidence.

10 Thank you, my Lady.

11 **LADY HALLETT:** Thank you very much indeed, Ms Doherty.
12 Mr Byrne.

13 **Submissions on behalf of the Welsh Government by MR BYRNE**

14 **MR BYRNE:** Thank you, my Lady.

15 Good afternoon, prynhawn da. I appear on behalf of
16 the Welsh Government.

17 During the pandemic, the procurement and
18 distribution of key healthcare related equipment and
19 supplies in Wales was carried out by the NHS Wales
20 Shared Services Partnership working with the Life
21 Sciences Hub and the Surgical Materials Testing
22 Laboratory.

23 The NHS Wales Shared Services Partnership is an
24 independent organisation established in 2011 to provide
25 services on behalf of NHS bodies in Wales including

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1 exceptions.

2 Between March 2020 and June 2022, over 1.4 billion
3 items of PPE were issued in Wales. Of these, over
4 500 million were issued to the social care sector. At
5 no point did Wales run out of PPE at the national level.

6 As my Lady is aware, procurement processes in Wales
7 were different from those in England. In Wales, there
8 was a strong centralised NHS procurement system in place
9 before the pandemic, and there were no high priority or
10 VIP Lanes at any time.

11 All offers to supply PPE or other key healthcare
12 equipment and supplies in Wales was subject to the same
13 transparent and rigorous processes. As a result, Wales
14 did not encounter the problems that were experienced in
15 England. No reports were required to be made to the
16 Welsh Government's Head of Counter Fraud in respect of
17 PPE or other healthcare procurement during the pandemic,
18 nor were any reports required to be made in respect of
19 conflicts of interest, preferential treatment or
20 suspected or attempted fraudulent attempts to secure
21 contracts.

22 The Welsh Government had no cause to report
23 suspected PPE fraud to the police or to the Crown
24 Prosecution Service.

25 Wales also did not experience the same level of

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1 procurement. It is the central procurement body for key
2 healthcare equipment and supplies in Wales.

3 During the pandemic it carried out all the
4 operational procurement for NHS bodies and, from
5 March 2020, it was also the operational procurement body
6 for the Social Care Sector and the wider NHS in Wales,
7 including independent contractors in primary care, such
8 as GPs, dentists, pharmacies, and optometrists.

9 The types of PPE to be used in health and social
10 care settings were specified by the UK infection
11 prevention and control sales guidance.

12 Within that framework, the NHS Wales Shared Services
13 Partnership was responsible for decisions about what PPE
14 and other supplies to buy, in what quantity, from which
15 suppliers, and at what cost.

16 It was also responsible for contractual arrangements
17 and provisions, the use of framework agreements and
18 direct awards, the publishing of contract award notices
19 and the management of contracts once awarded. The NHS
20 Wales Shared Services Partnership also carried out
21 demand modelling, stock management, and distribution.

22 The Welsh Government's practical role in procurement
23 was limited. It provided funding, oversight and
24 support. It did not conduct procurement of healthcare
25 supplies or equipment apart from certain limited

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1 unusable or expired stock having to be written off or
2 destroyed as in England. In the two-year period ending
3 in April 2022, NHS Wales expenditure on PPE was some
4 £385 million, of which just over 3% was written off as
5 unusable due to shelf-life expiry. Although, of course,
6 any amount of waste is regrettable and must be
7 minimised, a figure of 3% represents a modest margin of
8 error in light of the fast-paced changes of the pandemic
9 and the overriding need to ensure that sufficient stocks
10 of PPE were available. Wales was also able to donate
11 some excess stocks to other countries during the
12 pandemic.

13 As noted earlier, the Welsh Government's practical
14 role in respect of the procurement and distribution of
15 key healthcare equipment and supplies during the
16 pandemic was principally to facilitate and provide
17 funding, oversight and support. It also enabled some
18 procurement through existing framework agreements and
19 engage with industry to stimulate the domestic supply of
20 key products.

21 As to funding, between 2020 and 2022, Wales received
22 £1.022 billion in consequential funding from the UK
23 Government for PPE. In the two-year period ending April
24 2022, NHS Wales' expenditure on PPE totalled
25 approximately £385 million.

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1 The Cardiff University Wales Governance Centre
2 estimated that the cost of PPE and the devolved element
3 of the Test and Trace system in Wales cost approximately
4 half the level of consequential funding stemming from
5 English spending on test and trace and PPE, representing
6 a £158 lower cost per person in Wales than in England.

7 As is set out in detail in the Welsh Government's
8 evidence, funding for the procurement and distribution
9 of healthcare equipment and supplies was subject to
10 scrutiny by ministers via the Star Chamber. Starting in
11 April defend ministerial PPE meetings also provided
12 a forum to raise and resolve any emerging issues at
13 a ministerial level and an opportunity to review details
14 of the current and future stock position and the
15 forwarded order pipeline.

16 Procurement was also subject to the oversight by the
17 Covid-19 Health Countermeasures Group and later the PPE
18 Sourcing and Distribution Group.

19 In addition to funding and monitoring PPE stock
20 supplies the Welsh Government recognised the need to act
21 quickly to secure the domestic supply of key products
22 which global markets would be unable to provide
23 reliably. In March 2020, the Welsh Government
24 established the Critical Equipment Requirement
25 Engineering Team, known by the acronym CERET, made up of

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1 the pandemic influenza stockpile worked as an effective
2 buffer, some items were inadequate and stocks were
3 exhausted much quicker than expected, meaning that Wales
4 needed to procure more PPE than initially anticipated to
5 meet demand. That was a difficult task because most
6 supplies came from China and India and, due to
7 an increased global demand for such supplies and
8 lockdown restrictions in those countries, they were
9 difficult to obtain.

10 In response, the Welsh Government adopted
11 a multi-pronged approach. It supported the procurement
12 of additional PPE supplies. It worked with other UK
13 nations to pool procurement efforts and provide mutual
14 aid, and it continued international supplies and
15 increased collaboration with Welsh businesses to produce
16 PPE domestically. At no time did Wales run out of PPE.

17 That said, even where there was sufficient PPE
18 stock, there were distribution challenges. As the
19 Inquiry heard in Module 3, there were instances of
20 healthcare workers in Wales who were unable to obtain
21 PPE or were so concerned about the availability of PPE
22 that they were forced to adopt unsafe infection and
23 prevention control practices. Although the Welsh
24 Government addressed the question of supply at
25 a national level, the Inquiry heard evidence during

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1 key individuals with specialist expertise in health
2 finance, procurement and innovation from both within and
3 outside government. CERET supported the development and
4 manufacture of new products and secured components, raw
5 materials and services to help meet the needs of Wales
6 during the early phases of the pandemic. This included
7 supporting the Welsh manufacturers to change their
8 existing production lines, to manufacture PPE and
9 explore new methods of production that aim to offer
10 public bodies a strong local supply chain.

11 CERET did not carry out any procurement of
12 healthcare related supplies, apart from a single
13 instance in respective components for continuous
14 positive airway pressure devices and materials to enable
15 volunteers to make scrubs. Together, these amounted to
16 a spend of less than £650,000, and these were the only
17 healthcare equipment or supplies directly procured by
18 any part of the Welsh Government for the health or
19 social care sectors during the pandemic.

20 My Lady, the Welsh Government is very aware that
21 an important if not predominant public concern will be
22 whether there were sufficient supplies of PPE available
23 to those working in the health and social care sectors.

24 In Wales, it was realised early in the pandemic that
25 the stock of PPE was diminishing very rapidly. Although

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1 Module 3, which the Welsh Government accepts, that
2 delivering PPE stock to local health boards did not
3 necessarily mean it reached the right hospital or the
4 right ward.

5 As the Inquiry knows, the Welsh Government is not
6 responsible for the operational delivery of social care,
7 nor does it directly fund the delivery of social
8 services or social care. That is the legal respond of
9 local authorities in Wales. Ordinarily, PPE for the
10 Social Care Sector was sourced by each local authority
11 for its local area and private providers were
12 responsible for sourcing their own.

13 However, early in the pandemic, local authorities
14 were experiencing difficulties in providing sufficient
15 amounts of PPE to the sector because global supply
16 chains were collapsing and PPE was in very high demand.

17 Following Welsh Government discussions with the NHS
18 Wales Shared Services Partnership and local authority
19 leaders, the Minister for Health and Social Services
20 announced on 19 March 2020 that the NHS Wales Shared
21 Services Partnerships procurement and distribution remit
22 would expand to include the Social Care Sector.

23 This allowed more effective central procurement by
24 the NHS Wales Shared Services Partnership than would
25 have been possible by individual local authorities.

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1 PPE to manage Covid-19 was provided for free to the
2 Social Care Sector in Wales during the pandemic. It was
3 also provided for free to independent NHS contractors in
4 primary care, such as GPs, dentists, pharmacies and
5 optometrists.

6 In conclusion, my Lady, as in all other modules, the
7 Welsh Government will do all that it can to help and
8 support the Inquiry's investigation.

9 Thank you.

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

11 Ms Murnaghan, there you are.

12 **Submissions on behalf of the Department of Health in**
13 **Northern Ireland by MS MURNAGHAN KC**

14 **MS MURNAGHAN:** My Lady, I appear on behalf of the Department
15 of Health in Northern Ireland, which I'll refer to in
16 the course of this submission as "the Department".

17 My Lady, the Department would like to, again, take
18 the opportunity to offer its sincere condolences to
19 those who have been bereaved because of Covid-19. It
20 extends its sympathy to the wider public who suffered
21 during the pandemic, both in terms of the virus and also
22 of the impact of the many measures that have been taken
23 to combat that virus.

24 My Lady, the Department recognises the effects of
25 Covid-19 are ongoing, and that the impact of the virus
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1 medical equipment, PPE, and other critical supplies.

2 We will also address the second facet of this
3 module, namely that of the distribution of equipment and
4 supplies.

5 My Lady, as we've said before, Northern Ireland in
6 this regard faced unique geographical and logistical
7 challenges, and efforts were made to ensure
8 a coordinated approach and an approach that prioritised
9 the safety of healthcare workers, patients and the
10 public.

11 In its corporate statement which has been provided
12 already to the Inquiry, the Department has explained how
13 medical equipment is generally procured in
14 Northern Ireland, and the Department believes that an
15 understanding of the outline of the procurement process
16 will be key to this module, and I'll set that out very
17 briefly.

18 In Northern Ireland, the Northern Ireland Public
19 Procurement Policy was agreed by the Northern Ireland
20 Executive in 2022. That policy requires all
21 departments -- and not just the Department of Health,
22 but all departments, agencies, non-departmental public
23 bodies and public corporations -- to carry out all
24 procurement activities by way of a documented service
25 level agreement. And that is carried out with the
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1 is still being felt by many individuals as well as the
2 wider health and social care system. Like in previous
3 modules, the bravery, commitment and professionalism of
4 health and social workers across Northern Ireland must
5 be praised.

6 In this submission, my Lady, the Department would
7 also like to thank the staff of the Business Services
8 Organisation, which has been referred to today as BSO,
9 who worked behind the scenes in exploring potential new
10 procurement routes for medical equipment and the supply
11 of personal protective equipment. This was at a time
12 when the global supply chain was experiencing extreme
13 pressure. The Department wishes also to thank those who
14 assisted in the distribution of that vital equipment.

15 The Covid-19 pandemic presented unprecedented
16 challenges to the public health systems worldwide and it
17 is important to acknowledge that the work carried out by
18 these staff members was integral to protecting frontline
19 workers and the wider population.

20 Now, my Lady, the Department's role in procurement
21 is somewhat limited in comparison to these areas
22 examined in other modules to this Inquiry. However, by
23 this statement, we wish to outline the role that the
24 Department did play in the decisive actions and
25 decisions that were taken in respect of procurement of
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1 Central Procurement Directorate in the Department of
2 Finance or a relevant Centre of Procurement Expertise.
3 My Lady, you'll have heard of those Centres of
4 Procurement Expertise, or CoPEs as they have been
5 referred to this morning, and these are centres of
6 excellence with specialist procurement expertise across
7 Northern Ireland public sector, and they undertake
8 procurement activities in relevant sectors.

9 Although the Department uses three CoPEs generally,
10 the most relevant of which -- for this module is the
11 BSO PaLS procurement, which looks to the procurement of
12 healthcare equipment and supplies.

13 So throughout the pandemic BSO PaLS maintained its
14 direct operational responsibility for the procurement of
15 key healthcare equipment and supplies for Northern
16 Ireland's health and social care system.

17 The procurement role, therefore, of the Department
18 is one of overall responsibility and legal competence
19 for the procurement of goods and services that fall
20 within its remit.

21 As we've seen in earlier modules to this Inquiry,
22 the Department is the lead government department for
23 responding to the health consequences of emergencies, be
24 they from chemical, biological, radiological or nuclear
25 incidents, disruptions to the medical supply chain,
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1 human infectious diseases, mass casualties. This
2 department also leads on the civil contingency
3 arrangements for storage management and distribution in
4 Northern Ireland, including the Pandemic Influenza
5 Preparedness Programme (PIPP). And I'll return to that
6 shortly.

7 As I've highlighted, my Lady, at the start of this
8 statement, Northern Ireland faced logistical and
9 geographical challenges at a time when the global supply
10 chain was under extreme pressure. Despite these
11 pressures, BSO PaLS worked to expand capacity and to
12 meet demand, and played an important role in Northern
13 Ireland's pandemic response.

14 In working to scale its capacity to meet demand, it
15 is the overall view of the Department that BSO PaLS
16 performed well, particularly considering the
17 difficulties that they faced. The Department assisted
18 BSO PaLS in securing ministerial approval for
19 establishing a Dynamic Purchasing System for PPE. This
20 Dynamic Purchasing System, or which we've referring to
21 as the DPS, effectively allowed BSO PaLS to access
22 a pool of essentially pre-approved suppliers. This
23 thereby enabled access to supplier routes more quickly.

24 The establishment of the DPS was in recognition of
25 the significant increase in demand which had been

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1 Services Division, the contract was effectively
2 a cross-departmental arrangement and was signed by the
3 Department's previous minister, the First Minister, and
4 the Deputy First Minister, all on behalf of the Northern
5 Ireland Executive.

6 My Lady, if I could now turn to the second limb of
7 this module, being the distribution of medical
8 equipment.

9 The emergency planning branch in the Department
10 managed the stockpile of Pandemic Influenza Preparedness
11 Programme, both before and during the pandemic. BSO was
12 responsible for requesting the release of that PIPP
13 stock at the start of the pandemic, which the Chief
14 Medical Officer approved.

15 The Department established a PPE strategic cell on
16 the 23 March 2020, and the aim of that cell was to
17 prioritise the supply and distribution of PPE for the
18 HSE and to monitor the distribution of PPE from trusts
19 into the independent sector.

20 The cell also oversaw the introduction of a revised
21 process for Health and Social Care Trusts to order
22 personal protection equipment on the high demand
23 management list.

24 My Lady, this revised process was aimed to ensure
25 a more even distribution of stock across all health and

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1 encountered in the first wave, and was considered an
2 opportunity to mitigate supply chain issues such as the
3 rapidly changing supply and demand position.

4 So, my Lady, the Department, in conjunction with the
5 Northern Ireland Executive, explored many channels, both
6 locally and internationally, in an attempt to procure
7 a PPE for Northern Ireland and, in respect of this,
8 officials in the Department, BSO and the Department of
9 Finance, worked in collaboration with officials from the
10 Executive Office, and in this collaboration they were
11 able to purchase significant stock on behalf of Northern
12 Ireland directly from China. That became colloquially
13 known as "the China contract". This contract was with
14 a company that had been identified by the Northern
15 Ireland Bureau in China and Invest NI and had been
16 approved by the Chinese government to export PPE.

17 Conscious of the need to ensure value for money,
18 several pieces of work were undertaken and they included
19 a due diligence report for the Department of Finance,
20 an assessment of value for money that was carried out by
21 BSO, and validation of the products by experts in
22 infection and control from the Medicines Optimisation
23 and Innovation Centre.

24 So while this Chinese contract was led by BSO PaLS,
25 and the Department of Finance's CFP Supplies and

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1 social care sites, and for trusts to be able to maintain
2 local stock levels higher than what would normally be
3 expected.

4 In addition to this, there was an oxygen supply
5 working group which was established and that worked with
6 the Health and Social Care Trusts, and the existing
7 regional oxygen supplier, BOC, and their aim was to
8 coordinate and authorise a prioritised work plan to
9 enhance the trust's infrastructure and capacity for
10 oxygen supplies at that time.

11 Thereafter, with the development of lateral flow
12 tests, the Health Minister approved the establishment of
13 a Northern Ireland SMART -- smart meaning Systemic
14 Meaningful Asymptomatic and Repeated Testing, a SMART
15 programme board, and that was done in the Department in
16 March 2021.

17 The board had advice and had fulfilled an advice and
18 administrative role in relation to some aspects of
19 distribution and worked very closely with DHSC, UKHSA,
20 BSO and a range of other local delivery partners to
21 assist at times, coordinating the distribution of those
22 lateral flow tests to sites across Northern Ireland.

23 Therefore, my Lady, to conclude, we'd like to say
24 yet again that we welcome the opportunity to provide
25 this opening statement. We hope that our input into

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1 this module and this overview, which summarises the role
2 of the Department, will be useful in setting the scene.
3 We also wish to reiterate our thanks to the health and
4 social care workers, and officials in BSO, departmental
5 officials, all of whom have been instrumental in the
6 fight against Covid-19, and we welcome this module of
7 the Inquiry, hope to learn lessons from this, and
8 consider what things could have been done better and to
9 learn from those who did differently.

10 Thank you very much.

11 **LADY HALLETT:** Thank you very much indeed, Ms Murnaghan.

12 Ms Stober, I think you're wearing two different but
13 related hats?

14 **MS STOBER:** Yes, my Lady, can you hear me?

15 **LADY HALLETT:** I can, thank you.

16 **Submissions on behalf of the Local Government Association
17 and the Welsh Local Government Association by MS STOBER**

18 **MS STOBER:** Excellent, thank you. I represent the interests
19 of both the Local Government Association and the Welsh
20 Local Government Association.

21 I shall first start with the submissions of the
22 Local Government Association but I'd like to say, on
23 behalf of both associations, I extend their condolences
24 to all of those who suffered the terrible effects of the
25 pandemic, those who lost lives of families and those who

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1 networks were suboptimal.

2 When the pandemic started in early 2020, the
3 mismatch between the preparation that had been made and
4 the actual need for PPE was soon very evident.

5 The greatest challenges with PPE procurement
6 concerned a shortage of suitable PPE for those that
7 needed it, the difficulty in procuring it, given the
8 surge in global demand, and the lack of clear and
9 accurate guidance about what type of PPE could be used,
10 in which settings, such as mortuaries, children's
11 residential care homes and special schools, and for
12 which client groups.

13 The responsibilities, including producing plans of
14 councils in civil and health emergencies, had already
15 been set out in paragraphs 26 to 40 and paragraphs 90 to
16 164 in the witness statement the LGA provided in
17 Module 1, JK/13, INQ000177803.

18 The issues of the shortage of suitable PPE and the
19 difficulties in procuring had been considered in
20 previous preparedness exercises, but they had proceeded
21 on the wrong basis, as the Inquiry has already noted.

22 It was therefore entirely predictable that, when the
23 pandemic started, councils and the wider care provider,
24 were very worried about the increased demand and
25 associated cost of sourcing and providing PPE during the

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1 continue to suffer the effects of the pandemic.

2 The Inquiry will know that the Local Government
3 Association, having all but two local authorities as
4 members, is the voice of the local government.

5 This opening statement for Module 5 seeks to
6 highlight key points from the witness statement from the
7 Chief Executive Joanna Killian.

8 It aims in particular to highlight the lessons that
9 must be learned in order to enable local government to
10 deal with procurement in the context of any future
11 pandemic with the greatest resilience and preparedness.

12 Ms Killian's statement emphasises that future
13 national planning processes must involve local
14 authorities, along with those organisations and bodies
15 such as care provider organisations delivering the
16 services that require PPE.

17 This proposition should be uncontentious, but her
18 statement makes clear why it is so important. The fact
19 is that the pandemic started in early 2020:

20 Local government had not been adequately engaged in
21 the planning process, such as Cygnus.

22 There were found to be inadequate supplies of PPE.

23 The adult social care sector in particular was
24 adversely affected because of the shortage, both when
25 supplies were redirected to the NHS, or distribution

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1 pandemic, a cost that the adult social care sector had
2 previously not had to consider and was not prepared for.

3 Councils and the wider care sector also struggled
4 with changes in instructions and guidance on PPE use,
5 which exposed staff, patients, clients and service users
6 to risks.

7 Of course, it did not fall to the LGA to remedy
8 these defaults. Its primary role was to ensure that
9 government knew about the stresses and strains at the
10 level of local government and, conversely, local
11 government were aware of the steps taken by central
12 government, including the changes of procedures, such as
13 the responsibility for procuring PPE and then holding
14 and distributing stocks.

15 This role is fully explained in Ms Killian's
16 statement and does not need to be repeated in this
17 opening. What can be emphasised is that, through this
18 role, the LGA was in a very strong position to see the
19 problems and articulate them. Above all else, the LGA
20 sought to improve understanding the practicalities of
21 finding, holding and distributing PPE was absolutely
22 essential.

23 That was an issue of crisis management of the
24 greatest importance. Ms Killian has put it in this way:
25 due to the combination of government planning and PPE

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1 stockpiling, based on the assumption of an influenza
 2 pandemic, reliance on a just-in-time approach to the
 3 delivery of equipment beyond pre-existing stockpiles,
 4 a lack of planning in the UK to be able to put in place
 5 alternative production plans to respond to the global
 6 shortage of PPE, when the Covid-19 pandemic hit the UK,
 7 the UK began from a place of significant disadvantage
 8 with insufficient PPE resources to supply the NHS,
 9 Social Care Sector and frontline workers, and inadequate
 10 mechanisms to rectify this.

11 It is obvious that, if these were to recur in the
 12 future, no lessons would have been learnt from the
 13 Inquiry. That is why she has emphasised that the UK
 14 national planning needs to consider the following:

15 1. Which setting and workers will require access to
 16 PPE; what sort of PPE they will need; how much PPE will
 17 be needed as a result; and the relevant specification
 18 for that PPE.

19 2. Where that PPE is sought from at a time when
 20 global demand for PPE will peak and supply chains will
 21 be disrupted, whether that is through stockpiles, the
 22 ability to make a step change in domestic production in
 23 a matter of weeks or a combination of both.

24 3. The distribution processes and plans needed to
 25 ensure PPE can be delivered in a timely manner to

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1 will discuss in relation to Wales.

2 This network was, at the material time, the
 3 all-Wales forum to support local procurement
 4 collaboration and knowledge sharing. It worked then as
 5 it does now: to coordinate collaborative procurement
 6 activity and knowledge sharing across local government
 7 in Wales and with the wider public sector, including the
 8 Welsh Government.

9 The work of procurement as it related to Adult
 10 Social Care was supported by the National Commissioning
 11 Board. Accordingly, within Wales, there was a sound
 12 basis for co-ordination of effort to make sure that
 13 procurement worked well.

14 The issues of concerns lay elsewhere. As the
 15 Inquiry will already know from Modules 1 and 2, in the
 16 years before the pandemic, the work on resilience and
 17 operation was inadequate.

18 Dr Llewelyn has put the point in this way: to the
 19 knowledge of the WLGA, there have been no specific
 20 preparation exercises for the procurement sector, nor
 21 have procurement officials been involved within the
 22 range of national and local exercises undertaken. All
 23 local authorities in Wales are required to undertake
 24 emergency planning with a pandemic being one of the many
 25 emergencies that are planned for.

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1 everyone who needs it.

2 The Inquiry is asked to make these points explicitly
 3 in its report on this module. If it does, the
 4 recommendation can provide a firm foundation for
 5 building England's resilience and preparedness. If this
 6 does not occur, the same problems she has noted will
 7 recur. That simply cannot be allowed to happen.

8 My Lady, I now turn to the submissions of Local
 9 Government Association. Again, as the Inquiry will
 10 know, the Welsh Local Government Association represents
 11 the voice of local government in Wales. All 22 local
 12 authorities are members of WLGA.

13 This opening statement seeks to highlight key points
 14 from the witness statement of the chief executive,
 15 Dr Chris Llewelyn. His statement sets out much detail
 16 of the many meetings that took place within Wales at
 17 both the political and officer level. It is not
 18 necessary in this opening to detail these, but the
 19 Inquiry has the exhibits that relate to them.

20 There is much that went well in Wales in terms of
 21 discussions about procurement. Thus, Wales benefited
 22 greatly from the work of the National Procurement
 23 Network, which brought together the heads of procurement
 24 from each of the 22 Welsh authorities and was
 25 specifically concerned with the issues which this module

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1 Much of the planning is undertaken in cross-public
 2 sector partnership and will include plans for care homes
 3 and the wider care sector.

4 Medical provision is the responsibility of the NHS
 5 in Wales, and pandemic stocks for emergency supplies of
 6 medical equipment and supplies are procured, stored and
 7 distributed by NHS.

8 Reflecting on the experiences of Covid-19 pandemic
 9 and the importance of securing supplies of PPE for
 10 Wales, WLGA would expect to see the procurement sector
 11 included within any future exercises.

12 Inevitably, without national preparatory exercises
 13 in Wales, there was a significant tension between the
 14 work of the government to support the NHS in Wales, and
 15 an equivalent urgency being given to the needs of local
 16 government.

17 Moreover, guidance on the way to approach these
 18 needs was missing or inadequate and did not initially
 19 help to resolve the tension. Local authorities were
 20 therefore left to their own devices to ensure adequate
 21 procurement, placing their own orders and chasing their
 22 leads.

23 Dr Llewelyn points out that this also led to
 24 problems of a very specific kind, because non-compliant
 25 stock was sometimes supplied and price gouging occurred.

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1 Individual councils therefore had to be alert to risks
2 involved in their own procurement decisions, balancing
3 cost and size of order in the context of rising demand
4 and prices. Of course, it left councils open to
5 exploitation and at risk of receiving poor quality
6 stock.

7 In the context of a worldwide pandemic, this was
8 very far from an optimal approach, setting England and
9 Wales in conflict, though, fortunately and very much to
10 their credit, there was a spirit of cooperation between
11 Welsh authorities.

12 Dr Llewelyn notes the analysis of Professor James
13 Downe of Cardiff Business School:

14 "There is no doubt that nationally coordinated
15 collective response would have helped mitigate the
16 problems of supply and price of PPE. The initial phase
17 of council working independently to procure PPE
18 continued for far too long before cross-sector
19 collaboration was put in place. It was argued that it
20 was only when NHS supplies were stabilised that the
21 Welsh Government attention turned to the care sector.

22 "Local [authorities] did their best in sharing
23 information about suppliers and did not seem to abuse
24 the system by procuring more than their 'fair share'.
25 Rather than there being competition between councils,

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1 receipt of care."

2 The Inquiry is therefore asked to recommend that in
3 the preparation for another pandemic, WLGA is closely
4 involved, Welsh Government ensures that local government
5 is not required to manage risks on a piecemeal basis
6 and, finally, that there is a parity of preparation for
7 the needs of both the NHS and local government.

8 Thank you, my Lady. We continue to assist in this
9 Inquiry.

10 **LADY HALLETT:** Thank you very much indeed, Ms Stober.

11 Ms Hannaford.

12 **Submissions on behalf of the Cabinet Office by**
13 **MS HANNAFORD KC**

14 **MS HANNAFORD:** Thank you, my Lady.

15 This is the opening statement on behalf of the
16 Cabinet Office. The Cabinet Office, including
17 Number 10, remains committed to assisting the Inquiry's
18 investigations across all modules. It continues to
19 provide assistance to both ministers from the previous
20 administration and to current and former civil servants,
21 so as to ensure that the Inquiry is provided with the
22 best evidence available.

23 The Cabinet Office has provided extensive material
24 to assist the Inquiry's investigations in this module.

25 This has included three detailed written corporate

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1 the ethos was one of working together and sharing
2 intelligence. There were also examples of cross-border
3 working as masks were received in Wales from Scotland in
4 April 2020 and Wales sent a consignment of masks to NHS
5 England in May 2020 as part of the Mutual Aid Scheme.
6 Overall, more stock was provided by Wales to other
7 countries than they received.

8 "There are lessons to be learned around supply,
9 particularly the resilience on international supply
10 chains and the risks involved in these chains breaking
11 down. Welsh councils generally found that their
12 pre-pandemic framework suppliers did not deliver. It
13 was the off-framework suppliers who provided better
14 pricing, availability and were able to work smarter and
15 deliver products. There are case studies of good
16 practices in onshore production of PPE in Wales,
17 including RotoMedical, which has provided Welsh-made
18 face coverings at scale for pupils in Welsh schools.

19 Dr Llewelyn concludes:

20 "... In the eventuality of a future pandemic, the
21 WLGA considers it imperative that these working
22 arrangements be reached in a much shorter time frame,
23 minimising the risks borne by individual local
24 authorities and their procurement expertise, and
25 reducing potential harm faced by those providing and in

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1 witness statements from Gareth Rhys Williams, then the
2 Government Chief Commercial Officer, Clare Gibbs,
3 currently the Joint Interim Government Chief Commercial
4 Officer, and Mark Cheeseman, Chief Executive of the
5 Public Sector Fraud Authority. These statements are
6 supplemented by significant disclosure and support for
7 number of individual witnesses.

8 The Cabinet Office recognises that there has been
9 significant public interest in procurement during the
10 pandemic, including allegations of fraud and cronyism.
11 It takes these allegations seriously, and is keen to
12 receive the Inquiry's findings. The government is
13 committed to introducing a duty of candour on public
14 authorities, to improve transparency and accountability,
15 and has appointed a Covid Counter-Fraud Commissioner.
16 We encourage the Inquiry to consider the changes the
17 government is already making when formulating its
18 recommendations.

19 The scale of the challenge posed by the pandemic was
20 unique in peacetime. This included the need for the
21 government to source significant volumes of key goods
22 and services with extreme urgency, in an environment of
23 considerable international market disruption and
24 competition.

25 For example, up to 20 times the normal volume of PPE

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1 was needed. Commercial professionals bought essential
2 equipment for frontline health and social workers, and
3 enabled a national testing network to be set up from
4 scratch.

5 Staff sought to secure deals with scarce PPE in
6 order to allow the NHS to continue to function. There
7 were pressures on them to reassure ministers, the press,
8 and the broader public, that the system was working and
9 that they were moving with speed.

10 The work undertaken by Cabinet Office staff was wide
11 in scope, carried out at great pace, in improvised and
12 usually virtual teams, and facing unprecedented market
13 conditions. This activity supported our ability to
14 combat the virus, supported the NHS, and ultimately
15 helped protect the public.

16 Ministers and officials from the Cabinet Office had
17 key roles in for meeting and executing procurement
18 during the pandemic. First, Cabinet Office ministers,
19 including the Prime Minister, with support from
20 officials, provided a strategic response.

21 Second, the Cabinet Office provided the public
22 sector with prompt guidance on policy applicable in
23 emergency procurement.

24 Third, the Cabinet Office directly led one element
25 of procurement activity, the Ventilator Challenge.

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1 regulation 32, particularly when time was limited,
2 because the small amount of available stock would
3 otherwise be sold to competing countries.

4 As to the operational response, firstly ventilators.
5 The Cabinet Office led the Ventilator Challenge, an
6 initiative to design and build new ventilators in the
7 UK. Immediately prior to the pandemic there were no
8 intensive care ventilators made in the UK. In
9 March 2020 DHSC anticipated that up to 90,000 patients
10 might need them while the NHS had stocks of
11 around 7,000.

12 A number of companies with experience of developing
13 medical technology were tasked by the Cabinet Office
14 with designing a simple mechanical ventilator that could
15 be made in the UK. These design companies were paired
16 with manufacturing partners who could rapidly scale up
17 production. By the end of March 2020 the first
18 manufacturing contracts were signed and in April a new
19 production line was being commissioned at a factory in
20 Sweden. The initiative delivered 15,000 ventilators
21 within four months, compared to the three to seven years
22 typically taken to design and approve new products.

23 Second, PPE. In March 2020, it became clear that
24 the amount of PPE likely to be needed by the health and
25 social care sector would rapidly exhaust the

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1 And fourth, Cabinet Office commercial staff were
2 redeployed from their normal role to support DHSC and
3 the NHS on other key procurement activities of interest
4 to this Inquiry, including PPE and testing.

5 Public sector procurement is required to be carried
6 out in accordance with the Public Contracts Regulations
7 2015. It was apparent at the outset of the pandemic
8 that the time needed to execute competitive procurement
9 procedures under the regulations in many cases would not
10 enable the government to procure items or services at
11 the pace required. For example, a competitive dialogue
12 procedure typically takes months to complete.

13 The Cabinet Office issued a Procurement Policy Note
14 in March 2020 explaining the options available to
15 procure correctly at the necessary speed. These
16 included the use of accelerated procedures, the use of
17 existing frameworks, and the use of the flexible
18 emergency procurement procedure provided by
19 regulation 32, which allows direct awards of contracts
20 for cases of extreme urgency brought about by
21 unforeseeable events where the usual time limits cannot
22 be complied with, exactly the situation the UK found
23 itself in when competing with other countries to obtain
24 globally scarce PPE.

25 It was frequently necessary to rely on

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1 pre-pandemic stockholding and the supply chains of the
2 suppliers who had been used before the pandemic. These
3 suppliers struggled to fulfil existing orders and could
4 not respond to the sudden and enormous leap in demand.
5 In addition, the existing systems and structures of the
6 principal buying organisation, SCCL, were not designed
7 to cope with the many new suppliers.

8 DHSC set up a Parallel Supply Chain to radically
9 increase capacity. A Cabinet Office team was deployed
10 to set up the buying arm of the Parallel Supply Chain,
11 the PPE Buy Cell, on around 21 March 2020. This team
12 quickly grew to almost 800 people, including over 50
13 from the Cabinet Office. More than 18 billion items of
14 PPE were ordered in 15 weeks of operation.

15 The UK buy stream, one of the four buying streams in
16 the Parallel Supply Chain, received thousands of offers
17 from suppliers all over the world. These potential
18 suppliers were instructed to fill in a web form. The
19 number of offers quickly exceeded the capacity of the
20 PPE Buy Cell to process them, some 3,000 by
21 7 April 2020, and 25,000 over the 15 week period of the
22 Buy Cell.

23 Many such suppliers, some frustrated by what they
24 saw as delays in processing their offers, appealed to
25 their MPs, to ministers and to the DHSC and NHS

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1 officials directly, and this resulted in requests for
2 follow-up.

3 Those MPs and senior officials often, in turn,
4 contacted the Buy Cell to find out what had happened to
5 the offer. Referrers wanted to know that good offers
6 were being picked up and processed. The pressure of
7 responding to these requests took up significant
8 resources within the Buy Cell. These two routes, direct
9 email and the web form, were in place at the beginning
10 of April. The direct email route became what is now
11 known as the High Priority Lane, which, in addition to
12 checking opportunities, worked as a handling team to
13 respond to the requests and to absorb the pressure.

14 There has been a significant amount of criticism of
15 the High Priority Lane and suggestions made that it was
16 a method for minister's associates to obtain contracts
17 improperly. This is dealt with in the Cabinet Office's
18 corporate witness statements.

19 Cabinet Office acknowledges that the judgment in the
20 PestFix judicial review proceedings considered the
21 question of whether there had been unequal treatment by
22 use of the High Priority Lane. The judgement stated
23 that the use of the High Priority Lane breached equal
24 treatment rules, although also stated that the specific
25 offers considered in the judicial review, that's from

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1 proportionately more offers on the High Priority Lane
2 received contracts than those on the non-High Priority
3 Lane, many of the offers on the non-high priority stream
4 were of poor quality.

5 Thirdly, testing. In March 2020, the effective
6 capacity to perform Covid-19 tests in the UK was
7 estimated at 3,000 per day. The Secretary of State for
8 Health and Social Care set a goal to be able to perform
9 100,000 tests by the end of April 2020. A Cabinet
10 Office team supported DHSC in buying equipment,
11 consumables and services to achieve this goal and
12 provided commercial leadership for the NHS Test and
13 Trace organisation until August 2020.

14 Expert evidence. The Inquiry has commissioned its
15 own experts to provide their views on both procurement
16 during the pandemic and wider supply chains landscape.
17 Although we have expressed some concerns about
18 Professor Sanchez-Graells's report, we have welcomed the
19 opportunity to provide comments on the draft reports and
20 encourage the Inquiry to consider these comments in
21 detail alongside the evidence.

22 Three key points in relation to lessons that can --

23 **LADY HALLETT:** I'm afraid I'm going to have to ask you to
24 bring it to a close.

25 **MS HACKER:** My Lady, yes.

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1 PestFix and Ayanda, would have very likely resulted in
2 the award of contracts, whether on the High Priority
3 Lane or not, based on the merits of the offers. It will
4 obviously be for the Inquiry to reach its own
5 conclusions on the evidence of the different witnesses.

6 The Cabinet Office at this point notes the following
7 key points: firstly, the priority and non-High Priority
8 Lane were both methods of entry into the Buy Cell. They
9 constituted only the first stage, an initial check or
10 opportunity stage. If considered worthwhile, offers
11 were passed through technical assurance and subsequent
12 processes and then approval. These stages were
13 independent of the High Priority Lane and applied to
14 both High Priority Lane and non-high Priority Lane
15 opportunities.

16 Second, a range of people referred offers to the
17 High Priority Lane, including parliamentarians from the
18 majority party at the time, as well as other parties,
19 doctors, union officials and health service managers.

20 And thirdly, those cases on the High Priority Lane
21 which obtained contracts did so because they passed
22 technical assurance and were selling required goods for
23 an appropriate price.

24 Almost 90% of suppliers referred through the High
25 Priority Lane were unsuccessful, and whilst

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1 Three key points in relation to lessons learned.
2 The Cabinet Office faced a number of difficulties,
3 including data collection, lack of stockpile, and the
4 challenging number of offers to the Buy Cell. The
5 appropriate solution, therefore, for the future,
6 requires careful weighing up.

7 Secondly, procurement regulation, as a result of
8 learnings for emergency procurement, changes were
9 incorporated into the Procurement Act 2023 to equip the
10 government to respond to future large-scale emergencies
11 effectively.

12 Then, thirdly, tackling fraud. The pandemic
13 prompted efforts to strengthen the government's response
14 to public sector fraud, including the PSFA, launched in
15 August 2022. In December 2004, the government appointed
16 a counter-fraud commissioner.

17 And finally, the Public Authorities (Fraud, Error
18 and Recovery) Bill intends to safeguard public money by
19 reducing public sector fraud, error and debt.

20 So, in conclusion, the nature and scale of the
21 challenge was unprecedented in peacetime for
22 procurement. Responding to this challenge required
23 a sustained effort by commercial staff to support the
24 NHS. The Cabinet Office welcomes the opportunity to
25 contribute evidence to this module, and is keen to learn

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1 lessons that will enable an effective commercial
2 response to any future such emergency.

3 Thank you.

4 **LADY HALLETT:** Thank you Ms Hannaford.

5 Last, but definitely not least, Ms Idelbi.

6 **Submissions on behalf of UK Health Security Agency by**
7 **MS IDELBI**

8 **MS IDELBI:** Thank you, my Lady. I appear on behalf of the
9 United Kingdom Health Security Agency, or UKHSA, as
10 I will refer to the agency. In this module about
11 procurement, the Inquiry has asked us to assist on the
12 procurement of Covid-19, polymerase chain reaction
13 tests, referred to as PCR tests, those that have to go
14 to a lab for processing, and lateral flow tests,
15 including, in particular, lateral flow antigen tests,
16 LFD tests, which through their wide use through the
17 pandemic we will all be familiar with, some of us may
18 have a box or two at home.

19 An issue that my Lady will be considering in this
20 module is whether the adequate balance was achieved
21 between speed, quality and cost.

22 That is an important question but it is one that
23 must be viewed in light of the circumstances at the
24 time, which are, such as your Ladyship has heard, the
25 need to buy in high volumes, at speed, in the face of
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1 NHS Test and Trace. In January 2020, PHE worked at
2 exceptional speed with international collaborators to
3 succeed in developing a Covid-19 PCR assay that went on
4 to underpin commercial Covid-19 PCR tests globally.
5 Additionally, PHE evaluated a variety of proposed
6 Covid-19 tests, including starting in late summer 2020,
7 90 different types of LFD tests in five months.

8 NHS Test and Trace was established on 28 May 2020 to
9 lead an at-scale testing and tracing service which
10 included making testing available at speed to meet the
11 government's announced testing targets.

12 From September 2020, NHS Test and Trace established
13 a dedicated commercial function to undertake the work to
14 get tests to the public.

15 Being able to identify whether somebody is
16 infectious is critical because it allows for a better
17 use of mitigation measures, particularly when there is
18 no established vaccine or known treatment.

19 Identifying the infected and infectious cases by the
20 use of PCR tests in the NHS workforce was aimed not only
21 at maintaining the health of those workers themselves,
22 but also facilitating the continuing availability of NHS
23 key workers to support the early response in 2020.

24 It's estimated that between June 2020 and April
25 2021, test, trace and isolate strategies prevented 1.2
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1 global competition, across disrupted supply chains, and
2 in the context of an ever-changing new virus.

3 That context, when considering this question,
4 includes the unique challenges experienced in the
5 procurement of tests: that tests had to be integrated
6 into complex distribution and digital systems; that the
7 way testing would be used was subject to continuous
8 debate and changing policies; but, most critically,
9 that, at the outset of the pandemic, a Covid-19 test did
10 not exist.

11 Tests had to be designed, developed, validated,
12 authorised, before they could be commercially rolled
13 out. So, in this extraordinary emergency, if the
14 quality of a test must meet a minimum efficiency
15 requirement, and if the loss of speed risks greater
16 losses in humans and economic terms, how should cost be
17 regarded in the balancing exercise?

18 As UKHSA said before, in lessons to be learnt now,
19 we must acknowledge that risk appetites change. After
20 the emergency, the question is what systems need to be
21 developed for a better response in the future that can
22 achieve an adequate balance between speed, quality and
23 cost, regardless of the infection pathogen.

24 UKHSA, in October 2021, brought together the health
25 protection elements of Public Health England, PHE, and
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1 to 2 million infections, and part of that capability
2 came from the rising availability of LFD tests, which
3 then paved the way to reduce restrictions until the
4 rollout of effective vaccines.

5 Getting to that point needed the confidence to
6 consider and progress novel technologies to evaluation,
7 accepting that not every option may yield success.

8 As with vaccines, the human and financial costs of
9 the pandemic framed a political risk appetite to make
10 significant investments in testing technologies, but if
11 the next pandemic were to involve a different pathogen
12 with different characteristics to Covid-19, the
13 political, commercial and operational responses may be
14 different. Science may offer different types of
15 testing.

16 So if that future pandemic requires a very different
17 type of test, how does one identify that test more
18 quickly, so that robust, commercial and operational
19 processes can be established with parallel speed?

20 It's important to acknowledge that any preparatory
21 work is understandably framed by funding priorities.
22 The cost of an always on, always ready system is
23 unlikely to represent value for money for the public.

24 UKHSA is building systems that are pathogen agnostic
25 and scalable, so that it can use those systems and its
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1 knowledge to respond to a new emerging infection.
 2 Similarly, UKHSA invites the Inquiry to consider
 3 recommendations that are pathogen agnostic, taking into
 4 account the benefits that the Procurement Act may be
 5 able to offer.

6 You and your team, as well as the Core Participants,
 7 will have our written submissions, and I do not propose
 8 to read them out. Rather, given the importance rightly
 9 placed on lessons learnt and noting the time, I want to
 10 highlight three key themes which have particular
 11 resonance for the future.

12 Firstly, a need to foster partnerships.
 13 Collaboration between government departments, four
 14 nations, the private sector, and academia were critical
 15 to the development and procurement of PCR and LFD tests.

16 Innovative science requires collaboration and
 17 significant public and private sector funding.
 18 Accordingly, UKHSA's commercial strategy highlights as
 19 a first priority establishing a range of partnerships to
 20 benefit from different kinds of collaboration.

21 Secondly, transparency. Transparency enhances
 22 internal confidence and oversight over contract awards,
 23 industry confidence in UKHSA as a partner, and of course
 24 public confidence. UKHSA prioritises transparency.

25 The Inquiry will consider the question: in what
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1 of the workforce later. Finding the adequate balance
 2 will involve challenging choices for elected decision
 3 makers on the appropriate funding available, and
 4 recommendations will need to reflect that delicate
 5 exercise, and be aligned across the commercial functions
 6 in government, who will again have to work together in
 7 a future pandemic for an effective pandemic procurement
 8 response.

9 My Lady, those are the submissions on behalf of
 10 UKHSA.

11 **LADY HALLETT:** Thank you very much indeed, Ms Idelbi, very
 12 grateful.

13 I think that completes all the submissions.

14 Mr Wald you don't wish to say anything further?

15 Very well, I'd like to thank everybody, both those
 16 who have made the oral submissions and the written
 17 submissions. Despite the reservations expressed by
 18 some, I feel confident that together we can investigate
 19 fully, fairly, and openly the relevant issues that this
 20 module presents, and if any improvements need to be
 21 made, that I can make the necessary recommendations.

22 So I shall return tomorrow morning at 10.00.

23 Thank you very much.

24 **(4.36 pm)**

25 **(The hearing adjourned until 10.00 am the following day)**

1 circumstances might a prioritisation system assist in
 2 the procurement of key healthcare equipment and supplies
 3 in an emergency?

4 Clearly, a system aimed at ensuring that offers of
 5 quality products are not missed when working at speed is
 6 important. But the value of such systems will be better
 7 understood when they are transparent, and the routes to
 8 entry for suppliers are clear for all.

9 UKHSA's commercial strategy is aimed at making it
 10 easier for businesses of all sizes and sectors to access
 11 opportunities to work with UKHSA, whether established
 12 international corporations or innovative start-ups,
 13 facilitating transparency in the contracting process.

14 And thirdly, commercial capability and expertise.
 15 As I've said, the successful procurement and deployment
 16 of tests required contribution of scientists, academics,
 17 and industry and, of course, many professionals in the
 18 commercial and operations teams whose efforts need to be
 19 acknowledged.

20 The task demanded a huge workforce, one that would
 21 not be cost effective to maintain beyond a pandemic.
 22 UKHSA's commercial work includes assuring exercise giant
 23 scaling capacity if a surge workforce is needed again.

24 Planning for a surge workforce itself involves
 25 balancing the cost now against the impact on the quality
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