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

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

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,

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.

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

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

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

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

It is worth re-emphasising -- and, my Lady, this is

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

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

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

course, cover those areas identified in its scope, as depicted here.

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

There it is. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

healthcare equipment and supplies during the pandemic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The stockpile was overseen by Public Health England

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

approximately £5 million.

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

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

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

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

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

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

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

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

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

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

The Parallel Supply Chain was organised into four

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

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

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

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

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

The Inquiry will examine the various differing

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

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

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

is what this module will seek to do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Were these resources better deployed elsewhere?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Government Internal Audit Agency, or GIAA, found

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

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

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

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

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

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

Thank you.

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

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

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

(11.45 am)

(A short break)

(12.00 pm)

LADY HALLETT: Mr Wald.

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

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

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

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

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

Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

According to the Department for International Trade:

"Speculators, opportunistic intermediaries and individuals had piled in, trading up prices exponentially. Some of the units we looked at changed ownership over five times in the past two weeks. The prices quoted were on average triple the usual retail price and at the peak of the market, many times over. We had entered a ventilator procurement 'Wild West'."

At the end of March 2020, even credible offers of

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

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

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

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

This manufacturing drive came to be known as the

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

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

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

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

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

rather than in a planned manner.

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

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

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

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

So far as ventilators are concerned, this model will

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

I move now to NHS Test and Trace.

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

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

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

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

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

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

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

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

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

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

On top of this, there are numerous technical

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

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

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

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

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

The regulators worked with DHSC and suppliers and

manufacturers of PPE in an attempt to simplify regulatory process, speed it up, and still guarantee the safety of end users. It granted easements for certain items, changing the requirements that suppliers had to comply with. The regulators also assisted DHSC in assessing the compliance of PPE procured by the Parallel Supply Chain.

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

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

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

The logistical challenge was immense and should not be underestimated. As the Chief of the Defence Staff, Sir Nicholas Carter stated on 22 April 2020:

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

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

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

From 6 April 2020, local resilience forums received

PPE for distribution to social care and other services that could not access PPE supplies in other ways. But most small social care providers and GPs, totally 20,000 individual providers, had signed up only until June 2020 to a new e-portal that allowed them to order free PPE directly from the Parallel Supply Chain for delivery through the mail service.

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

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

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

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

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

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

Wales also received logistics assistance from the

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

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

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

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

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

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

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

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

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

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

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

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

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

medical supplies and equipment.

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

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

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

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

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

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

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

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

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

Testing capacity through the purchase of equipment and testing consumables.

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

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

workforce was already under such pressure.

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

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

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

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

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

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

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

stock that were required by NHS England.

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

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

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

a more competitive process. As of March2022, it had awarded only two competitive contracts under this, totalling £38.3 million. This may reflect the large stocks built up under the emergency regulation contracts.

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

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

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

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

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

My Lady, that concludes the sections on the devolved

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

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

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

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

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

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

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

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

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

This itself was aggravated by many stages of the

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

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

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

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

Diversification of supply, the second theme.

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

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

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

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

Is there scope for a domestic emergency industrial

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

Penultimately, fairness in emergency procurement.

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

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

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

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

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

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

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

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

Mr Weatherby.

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

MR WEATHERBY: Thank you.

At paragraph 99 of his witness statement, Michael Gove states:

[As read] "Much has been written, broadcast and tweeted about the so-called scandal of PPE procurement. Almost all of it has been politically-motivated bilge."

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

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

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

Why was there no emergency procurement process

concentrating on existing suppliers, rather than a VIP Lane and a desperate shout-out to unknown and opportunist profit seekers?

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

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

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

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

In the coming days the Inquiry will have the opportunity to ask Mr Gove to assist us with which parts of the scandal are politically motivated nonsense and which are, in fact, not nonsense. Because it really is beyond argument from open source material, never mind

the evidence amassed by the Inquiry, that certain politically-connected individuals gained massively from contracts to supply PPE and medical provisions during the pandemic.

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

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

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

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

Having considered evidence from some witnesses who will appear before the Inquiry which indicated that VIP offers were not advantaged at the decision making stage,

the High Court concluded that, and I quote:

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

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

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

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

By not calling the suppliers, the Inquiry has deprived itself of calling to account those for whom political patronage appears to have been a key element of getting the contract. It's deprived itself of being

able to ask them how they came to make their bids, to explain their commercial expertise and experience and history in the areas they sought to supply, it's deprived itself of the opportunity to ask questions as to whether their attempts to source supplies interfered with established suppliers' efforts and drove up prices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a measure of accountability.

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

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

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

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

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

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

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

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

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

These and many more are the human costs of no proper

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

Thank you, my Lady.

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

(1.05 pm)

(The Short Adjournment)

(2.05 pm)

LADY HALLETT: Ms Campbell.

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

MS CAMPBELL: Thank you, my Lady.

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

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

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

Those consequences were felt at the time by frontline staff and their patients on hospital wards, in care homes and in their own homes, and they continue to have consequences, measured now by the ongoing impact on political confidence in the top echelons of government. It is hoped that the evidence you will consider in this module will enable you to make strong recommendations to minimise, so far as possible, frontline consequences in any future pandemic or health crisis, but it is also to be hoped that those witnesses from whom you will hear will carefully consider the evidence that they give against the need for this public inquiry to go some way to restoring public confidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

So what went wrong?

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

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

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

We recognised that the workload of BSO PaLS became

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

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

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

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

were the vulnerability of its residents.

The position for domiciliary care is still worse.

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

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

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

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

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

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

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

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

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

recommendations in each of those areas.

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

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

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

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

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

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

Thank you.

LADY HALLETT: Thank you very much indeed, Ms Campbell.

Ms Parsons.

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

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

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

More tragically, they experienced those shortages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"... the significant resource and operational

implications of doing so."

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

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

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

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

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

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

Thank you, my Lady.

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

Submissions on behalf of the Scottish Covid Bereaved by DR MITCHELL

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

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

DR MITCHELL: Hello? Yes.

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

From the material available so far, it appears that

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

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

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

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

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

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

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

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

we, the people, are being placed before profit.

These are the submissions of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell, I'm very grateful.

Who is next? Mr Thomas?

Submissions on behalf of the Federation of Ethnic Minority Healthcare Organisations by PROFESSOR THOMAS KC

PROFESSOR THOMAS: My Lady.

LADY HALLETT: Are you switched on?

PROFESSOR THOMAS: My Lady, can you hear me?

LADY HALLETT: Yes.

Are you switched on, Mr Thomas?

PROFESSOR THOMAS: I am.

LADY HALLETT: Oh, you are now.

PROFESSOR THOMAS: "The true measure of any society can be found in how it treats its most vulnerable members."

Ghandi.

My Lady, as we commence Module 5 of this Inquiry, we are presented with an opportunity to rigorously examine the procurement process during the Covid pandemic. We say that this module is crucial because it focuses on assessing whether these processes adequately consider and address the needs of the NHS diverse workforce and the communities they serve. There are also some key

questions for the Inquiry to explore, on the involvement and representation of Black, Asian and Minority Ethnic people in leadership roles, and decision making in the procurement processes.

We urge you and your team to scrutinise how measures implemented during the pandemic ensured that the procurement practice and processes were not only efficient but also equitable.

Our discussion today is particularly centred on understanding the impact of these practices and processes on Black, Asian and Minority Ethnic healthcare and social care workers who were disproportionately affected by the pandemic.

My Lady, we have said it before and it does bear repeating: the first ten doctors to die and lose their lives to the virus were from the Black, Asian and Minority Ethnic backgrounds. That these deaths were of Black, Asian and Minority Ethnic doctors, was not a coincidence.

These tragic losses, representing not just colleagues but also friends and family, underscored the dire consequences of structural and systemic inequalities deeply rooted in our society. FEMHO's members, who stand at the intersection of race and healthcare, lived the reality of structural and systemic

inequalities each and every day of the pandemic. They continue to do so and will continue to do so until real action is taken to ensure that society is equal, just and fair.

Black, Asian and Minority Ethnic staff now make up almost a quarter of the workforce overall, 24.2%; more than two fifths, 42%, of doctors, dentists and consultants; and almost a third, 29.2%, of nurses, midwives and health visitors. Yet, representation at board level is only 13.2%.

The figure for very senior managers is lagging at about 10.3%. This gross under-representation in decision making, including in procurement, has contributed to the disproportionate impact experienced by FEMHO's members. You see, my Lady, Module 5 provides a crucial opportunity to prevent future injustices and ensure that these disparities and the inequality and the equality duties designed specifically to minimise their impact and promote equality are never again forgotten or ignored within procurement processes in decision making.

We submit that the disproportionate impact of the pandemic and, in particular, its impact on ethnic minority home workers, should never be sidelined or an afterthought.

While we note that these issues were not addressed

in Counsel to the Inquiry's opening statement, we trust that the Inquiry will address these issues as we proceed in Module 5.

FEMHO considers that Module 5 examines how government procurement processes and procedures and decision making differentially affected ethnic minority communities and there are number of things that we'd ask you to look at. Firstly, we acknowledge this Inquiry's commitment to exploring these disparities but we urge you, my Lady, to ensure that these important topics are kept at the forefront of everything the Inquiry does, including now, within your assessment of procurement processes.

So what are the essential questions? My Lady, there are some important questions for your consideration. When you examine procurement strategies implemented during the pandemic, we invite you to ask the following: how? How were these strategies designed to reflect the needs of the NHS's diverse workforce?

Were considerations of diversity integral to the procurement process from the outset?

Were the procurement strategies in place sufficiently robust to address the urgent needs of all healthcare workers, particularly those from Black, Asian and Minority Ethnic backgrounds who faced

disproportionate risks.

What evidence was gathered to show that the measures taken during the procurement processes were effective in preventing losses of healthcare workers, especially amongst ethnic minorities?

Where? Where did these measures fall short and why?

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

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

What steps are now required to rectify these disparities?

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

Were any compliance measures effectively monitored and enforced?

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

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

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

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

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

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

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

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

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

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

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Mr Thomas.

Mr Stanton.

Submissions on behalf of the British Medical Association by MR STANTON

MR STANTON: Thank you, my Lady.

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

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

This statement covers the procurement, distribution

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

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

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

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

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

destroyed.

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

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

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

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

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

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

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

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

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

together to leave staff unprotected throughout the pandemic.

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

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

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

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

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

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

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

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

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

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

The risk of a sudden loss of oxygen pressure within

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

One resident doctor in England told the BMA that:

[As read] "It was mostly luck that our oxygen supplies did not fail."

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

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

Procurement and distribution of healthcare equipment are not just bureaucratic processes, they are a lifeline that provide critical protections and supplies to ensure the safety of those who work in the system and those that they care for. The failure to do this has impacted

the physical and mental health of healthcare staff, and the lack of transparency, robustness and value for money has damaged their trust and confidence in the systems that should have protected them and their patients.

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

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

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

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

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

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Mr Stanton.

Mr Smith.

Submissions on behalf of UK Anti-Corruption Coalition by MR SMITH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For example, many government PPE contracts lacked

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and to the Inquiry's scrutiny.

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

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

Thank you.

LADY HALLETT: Thank you, Mr Smith.

Mr Mitchell.

Submissions on behalf of the Scottish Ministers by MR MITCHELL KC

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

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

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

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

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

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

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

clinical experts, and with end users of products.

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

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

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

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

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

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

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

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

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

A framework contract was awarded by the Scottish

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

(3.15 pm)

(A short break)

(3.30 pm)

LADY HALLETT: Ms Doherty, there you are.

MS DOHERTY: *(Microphone off)*

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

MS DOHERTY: That's it now.

LADY HALLETT: That's it.

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

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

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

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

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

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

position.

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

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

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

A supply offers portal was set up to receive and

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

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

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

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

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

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

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

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

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

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

National Procurement staff responded to the

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

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

Thank you, my Lady.

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

Submissions on behalf of the Welsh Government by MR BYRNE

MR BYRNE: Thank you, my Lady.

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

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

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

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

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

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

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

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

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

exceptions.

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

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

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

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

Wales also did not experience the same level of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

LADY HALLETT: Thank you very much, Mr Byrne.

Ms Murnaghan, there you are.

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

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

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

My Lady, the Department recognises the effects of Covid-19 are ongoing, and that the impact of the virus

is still being felt by many individuals as well as the wider health and social care system. Like in previous modules, the bravery, commitment and professionalism of health and social workers across Northern Ireland must be praised.

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

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

Now, my Lady, the Department's role in procurement is somewhat limited in comparison to these areas examined in other modules to this Inquiry. However, by this statement, we wish to outline the role that the Department did play in the decisive actions and decisions that were taken in respect of procurement of

medical equipment, PPE, and other critical supplies.

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

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

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

In Northern Ireland, the Northern Ireland Public Procurement Policy was agreed by the Northern Ireland Executive in 2022. That policy requires all departments -- and not just the Department of Health, but all departments, agencies, non-departmental public bodies and public corporations -- to carry out all procurement activities by way of a documented service level agreement. And that is carried out with the

Central Procurement Directorate in the Department of Finance or a relevant Centre of Procurement Expertise. My Lady, you'll have heard of those Centres of Procurement Expertise, or CoPEs as they have been referred to this morning, and these are centres of excellence with specialist procurement expertise across Northern Ireland public sector, and they undertake procurement activities in relevant sectors.

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

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

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

As we've seen in earlier modules to this Inquiry, the Department is the lead government department for responding to the health consequences of emergencies, be they from chemical, biological, radiological or nuclear incidents, disruptions to the medical supply chain,

human infectious diseases, mass casualties. This department also leads on the civil contingency arrangements for storage management and distribution in Northern Ireland, including the Pandemic Influenza Preparedness Programme (PIPP). And I'll return to that shortly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much.

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

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

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

LADY HALLETT: I can, thank you.

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

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

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

continue to suffer the effects of the pandemic.

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

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

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

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

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

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

There were found to be inadequate supplies of PPE.

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

networks were suboptimal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

everyone who needs it.

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

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

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

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

will discuss in relation to Wales.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Llewelyn concludes:

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

receipt of care."

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

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

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

Ms Hannaford.

Submissions on behalf of the Cabinet Office by MS HANNAFORD KC

MS HANNAFORD: Thank you, my Lady.

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

The Cabinet Office has provided extensive material to assist the Inquiry's investigations in this module. This has included three detailed written corporate

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

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

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

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

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

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

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

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

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

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

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

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

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

It was frequently necessary to rely on

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Three key points in relation to lessons that can --

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

MS HACKER: My Lady, yes.

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

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

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

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

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

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

Thank you.

LADY HALLETT: Thank you Ms Hannaford.

Last, but definitely not least, Ms Idelbi.

Submissions on behalf of UK Health Security Agency by MS IDELBI

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

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

That is an important question but it is one that must be viewed in light of the circumstances at the time, which are, such as your Ladyship has heard, the need to buy in high volumes, at speed, in the face of

global competition, across disrupted supply chains, and in the context of an ever-changing new virus.

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

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

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

UKHSA, in October 2021, brought together the health protection elements of Public Health England, PHE, and

NHS Test and Trace. In January 2020, PHE worked at exceptional speed with international collaborators to succeed in developing a Covid-19 PCR assay that went on to underpin commercial Covid-19 PCR tests globally. Additionally, PHE evaluated a variety of proposed Covid-19 tests, including starting in late summer 2020, 90 different types of LFD tests in five months.

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

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

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

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

It's estimated that between June 2020 and April 2021, test, trace and isolate strategies prevented 1.2

to 2 million infections, and part of that capability came from the rising availability of LFD tests, which then paved the way to reduce restrictions until the rollout of effective vaccines.

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

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

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

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

UKHSA is building systems that are pathogen agnostic and scalable, so that it can use those systems and its

knowledge to respond to a new emerging infection. Similarly, UKHSA invites the Inquiry to consider recommendations that are pathogen agnostic, taking into account the benefits that the Procurement Act may be able to offer.

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

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

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

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

The Inquiry will consider the question: in what

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

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

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

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

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

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

of the workforce later. Finding the adequate balance will involve challenging choices for elected decision makers on the appropriate funding available, and recommendations will need to reflect that delicate exercise, and be aligned across the commercial functions in government, who will again have to work together in a future pandemic for an effective pandemic procurement response.

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

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

I think that completes all the submissions.

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

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

So I shall return tomorrow morning at 10.00.

Thank you very much.

(4.36 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X