Witness Name: Gareth Rhys Williams

Statement No:4

Exhibits: 124

Dated: 23 January 2025

**UK COVID-19 INQUIRY**

**FOURTH WITNESS STATEMENT OF GARETH RHYS WILLIAMS**

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I, Gareth Rhys Williams, will say as follows:

## A. INTRODUCTION

1. I make this statement in response to the request by letter dated 31 July 2024 for evidence under Rule 9 of the Inquiry Rules 2006 made on behalf of Baroness Heather Hallett, the Chair of the UK Covid-19 Inquiry ("the Inquiry"). By this statement, I intend to set out, where appropriate, matters relating to public procurement of key equipment and supplies across the UK public sector in relation to the Covid-19 pandemic in the period from 1 January 2020 to 28 June 2022.

2. I make this statement in addition to the Corporate Witness Statement dated 5 July 2024 given in my name in relation to Module 5 ("the Corporate Statement") and the statement I made in response to the request by letter dated 15 July 2024 for evidence under Rule 9 of the Inquiry Rules 2006 to the Inquiry (my "Third Statement"). I have also provided a corporate witness statement in Module 1 of the Inquiry, dated 28 April 2023 which was intended to give an overall summary of procurement issues in which the Inquiry might be interested.

3. This statement has been prepared with the assistance of Counsel and lawyers at the Government Legal Department. This statement sets out my personal knowledge and experience, as refreshed by documents or papers made available to me.

4. I have in the preparation of this statement been referred to a number of emails which were sent at the time. I should note that my personal work email address was monitored by a bolstered team of my assistants who would flag the most important emails received. This was due to the heavy load of emails received (I received over 10,000 emails in the first month of the pandemic up to 12 April 2020 and, in the period 1 February 2020 to 30 June 2020, my email account received and sent a total of 36,100 emails). I would not therefore see all emails, even those which were addressed to me. I did not have direct access to my office's general email address (cco@cabinetoffice.gov.uk) but my office

flagged the most important emails for me. Further, emails would be sent out from my address which had been authored by others.

## B. BACKGROUND

5. From March 2016, I was the Government Chief Commercial Officer ("GCCO"). I was appointed to this role in March 2016 after an open and fair recruitment process, to replace the first GCCO, Bill Crothers, who had left this post some six months earlier.

6. Prior to my appointment as GCCO, I held four chief executive roles in a variety of industrial and services companies: two listed companies (Vitec Plc and Charter Plc) and two private equity backed businesses (Capital Safety and PHS Group). I am a chartered engineer and spent my early career in 'just-in-time' operations and continuous improvement. I have a Master of Business Administration degree from Institut Européen d'Administration des Affaires (INSEAD) and over 30 years' experience managing a variety of companies.

7. I resigned formally from the Cabinet Office in late February 2024, working reduced hours in the Cabinet Office from 2 April until I left completely on 5 July 2024. I am currently the Chair of National Highways.

## C. ROLES AND RESPONSIBILITIES

8. I have set out my role in the procurement of key healthcare equipment and supplies, including the procurement of personal protective equipment ("PPE"), ventilators, lateral flow tests ("LFTs") and PCR testing equipment, in my Third Statement. I refer, in particular, to paragraphs 11 to 39 of that statement. I was not involved in the procurement of oxygen. That was dealt with by the Department of Health and Social Care ("DHSC").

9. My role generally as GCCO and that of the Central Commercial Teams was to shape not just how the Cabinet Office conducted its procurements, but all the other central government departments. In building the structures and methods used in the Government Commercial Function ("GCF"), I used my experience of functional models that I had seen in my corporate career. In particular, I used my experience of the utility of "hub and spoke" structures in preference to

imposed centralisation. I refer to a more detailed summary of my role as GCCO during the pandemic at paragraphs 8 to 10 of my Third Statement. As a note of particular relevance to this statement, at the time of the pandemic, I did not have the (informal) interactions and oversight with NHS procurement teams that has since arisen as a result of the pandemic. The NHS was not a department over which I had any jurisdiction.

## D. WORKING WITH MINISTERS AND DEVOLVED ADMINISTRATIONS

10. In respect of procurement of healthcare equipment and supplies, and save in the ways I have set out in the paragraphs below, I only very rarely worked with Ministers outside of the Cabinet Office. As examples of the rare occasions on which I communicated with Ministers outside the Cabinet Office, I believe I was on a call with Edward Argar, a then Minister of State for Health, about ventilators on 15 April 2020 (GRW/01 - INQ000421253) and separately another call with him on antivirals, and I had a few text exchanges with the Secretary of State for Health and Social Care ("the Health Secretary"), Matt Hancock, (who had been my first minister in the Cabinet Office when I joined) - not concerning decisions, but following his press appearances.

11. I did however work on the procurement of key healthcare equipment and supplies with a number of ministers in respect of the Ventilator Challenge. I was particularly tasked with upwards communication regarding ventilators to No.10, Matt Hancock, the Chancellor of the Duchy of Lancaster ("the CDL"), Lord Agnew and ministers from HM Treasury (as an example of this communication, see the submission on the Ventilator Challenge dated 11 April 2020: GRW/02 - INQ000513010). Also, as described at paragraphs 4.153 to 4.519 of the Corporate Statement, I was involved in the PPE and Test and Trace programs. Towards the end of both programs, there were some discussions with the Foreign and Commonwealth Office / Foreign, Commonwealth and Development Office, other officials (but not ministers) and others such as military doctors about giving away spare ventilators or spare PPE (GRW/03 - INQ000534524 and GRW/04 - INQ000534510). However, these discussions did not lead to a donation programme, due to concerns about liability, and usefulness for the potential recipient, because of the need for ventilators to be integrated into a wider ICU unit, which in many potential recipient countries was lacking (GRW/05 - INQ000534511).

12. The most active Cabinet Office minister involved with procurement, and therefore the minister with whom I worked the most during the Covid-19 pandemic, was Lord Agnew. He was the sponsor for the ventilator project, and reviewed the commercial spend cases submitted by the Commercial Assurance team (often referred to as 'commercial controls'). He acted, as much as was possible, to control spend by assuring that good commercial practice was followed during that period, when acquiring goods and services. I refer to paragraph 65 below in relation to Test and Trace and their call centre capacity as an example of this. As explained at paragraph 61 below, PPE was excluded from the controls.

13. The senior minister in the Cabinet Office at the time was the CDL, Michael Gove. He was not involved in procurement after the first few weeks except sporadically. I discuss at paragraphs 109-110 below an intervention he made during the ventilator challenge in relation to Dyson.

14. On a number of occasions, I was invited to present to the Prime Minister, ministers and the staff at No.10, particularly Dominic Cummings, on the progress I was making on the work in my area. Several of these presentations led to me being asked to look at particular aspects of Test and Trace where my previous industrial experience would be relevant. My work on those aspects is discussed further below.

15. I was also involved in the start up of a project run by the Department for International Trade, looking into the resilience of UK supply chains for wider industry, i.e. outside of public procurement (GRW/06 - INQ000534504). This evolved into Project Defend, in relation to which I attended the steering group for a number of months from May 2020 (GRW/07 - INQ000534506; GRW/08 - INQ000534507; GRW/09 - INQ000534508; GRW/10 - INQ000534509). As part of that project, I encouraged colleagues to run a brisk 'beauty parade' of a number of consultants, one of whom was picked to do the initial, urgent work (GRW/11 - INQ000534503).

16. My only other interaction with Ministers was at the Vaccine Taskforce Ministerial Panel meetings (see GRW/12 - INQ000534517 for the minutes of

such a meeting on 11 September 2020), which was the senior forum at which vaccine and related investments were discussed and signed off.

17. I was not involved in the distribution of healthcare equipment or supplies with ministers in the UK government beyond some initial informal conversations, and on warehousing options (GRW/13 - INQ000534487) or the devolved administrations beyond one early phone call. I think that call was with a Welsh colleague, Sue Moffatt. She wanted to know if they should be trying to build / buy their own ventilators (the answer being that the DHSC and Ventilator Challenge efforts were aimed at providing for the entire UK).

18. Except as above, and where I worked with DHSC and the Medicines and Healthcare products Regulatory Agency ("MHRA") and NHS clinicians on ventilators, PPE and Test and Trace testing provision, as further described in the Corporate Statement, I did not work with the public health agencies and NHS in the UK or devolved administrations in the procurement of healthcare equipment and supplies or on their distribution.

## E. DAILY PROCUREMENT MEETINGS

19. I attended near-daily meetings in relation to the Ventilator Challenge with Lord Agnew. These were set up around 19 March 2020 (GRW/14 - INQ000498215; GRW/15 - INQ000412594; GRW/16 - INQ000513549) and were referred to as "Covid-19 Daily Procurement Update" on 23 March 2020, "Covid-19 Daily Procurement Meeting" from 24 March 2020 to 6 May 2020 and "Ventilator Team Daily Update" from 7 May 2020 to 17 June 2020. It may have been intended for these to cover more than the procurement of ventilators initially and the initial invite lists were indeed longer (see the meeting of 20 March 2020) (GRW/17 - INQ000513324). However, the invite lists rapidly declined to just the Ventilator Challenge team, being around 8 of us (see the meeting readout from 23 March 2020 as an example of the focus on ventilators: GRW/18 - INQ000478017).

20. Lord Agnew held these meetings initially daily in the evening, with me, Clare Gibbs, and representatives from PA Consulting who were acting as project managers for the Ventilator Challenge. To support that meeting, there were

daily meetings in the morning to review work done overnight and in the afternoon to go through the pack that would be presented to Lord Agnew in the evening. The purpose of the meeting was to track the progress of the development of the UK designed and built ventilators in the Ventilator Challenge, and give Lord Agnew (and consequently DHSC, No10 and others) as good an estimate as we could of when we could expect ventilators to be delivered, what volumes and of what type and specification. For further detail on who routinely attended these meetings, I refer to paragraph 4.18 of the Corporate Statement.

21. I have been asked by the Inquiry about "Daily Procurement Meetings" as though their scope extended beyond the Ventilator Challenge (as set out above). I am not aware of any other meetings called 'Daily Procurement Meetings'. It may be that there was one run in DHSC during the pandemic, which I would not attend.

22. I have been asked questions by the Inquiry which effectively ask how the outcomes at the "Daily Procurement Meetings" could be improved. Assuming the Daily Procurement Meeting was one within the DHSC as above, the most important input would be to ensure that the discussions at the meetings were based on current usage and stock figures. Such figures would allow the forecasts - and hence what the buying teams were being asked to hunt for - to be updated and kept current. For instance, in the Ventilator Challenge, when we discovered that the expected number of patients was flattening and that fewer ventilators were going to be needed, we did manage to generate a discussion with DHSC Ministers that led to required build volumes being reduced. We immediately started a program to halt the procurement of what would have turned into excess components, and the disposal/recycling of components already received or procured and then considered surplus (GRW/19 - INQ000512992 and GRW/02 - INQ000513010). This is discussed further at paragraphs 4.97 to 4.112 of the Corporate Statement. I discuss the benefits of current usage and stock figures further below.

## F. PRINCIPAL ISSUES WITH PROCUREMENT AS THE UK ENTERED THE PANDEMIC

23. In my experience, the principal issues at the start of the pandemic were not with 'procurement' as narrowly defined as the act of 'buying' a wide range of products and services, but with understanding the extent and validity of PPE and ventilator stockpiles, determining the required specifications and forecasting the demand for them. The problems with 'procurement during the pandemic' that the Inquiry has highlighted elsewhere seem to relate principally to PPE, where the abnormally high market prices attracted in a number of new and untested middlemen, many of whom were selling valid product, but many who weren't. This put an unusual onus on the procurement, due diligence and quality assessment teams to try to winnow the good offers from the bad. That work is covered more fully in paragraphs 4.369 to 4.384 of the Corporate Statement. For substantially all of the other things that were bought in extremis (e.g. PCs for school children, food boxes, mortuaries, vaccines etc.), their activities went well and have attracted much less interest. The issues related to ventilators were as much around rapid product development, testing and scale up, as they were about understanding demand and procurement; they were handled through the Ventilator Challenge as discussed at paragraphs 4.1 to 4.152 of the Corporate Statement.

24. As already laid out in paragraphs 4.289 to 4.296 of the Corporate Statement, the pandemic posed some unique challenges. I have included recommendations on how to handle these issues at section R below. Many of these issues were not about procurement in general during the pandemic, but stemmed from the very difficult position we were in at the start of the pandemic, due to the combination of:

    (a) Vast and unexpected demand, globally;

    (b) Reducing worldwide supply;

    (c) Export restrictions by other countries; and

    (d) The lack of appropriately large safety stocks of the items needed by this particular pandemic to keep us going until the supply chain could react and kick back in.

25. That is to say, problems in procurement initially arose due to a lack of sufficient strategic stocks, with a key problematic area being PPE where our volumes of purchases very rapidly grew 20-fold. The things we were trying to buy just became very rare in the global setting and consequently the price went through

the roof. Usage of PPE was initially much faster than supply (which is the same issue as that faced by defence departments currently trying to acquire sufficient quantities of ammunition to support Ukraine). This made the build-up of stocks very challenging.

26. Pandemic stock policy is rightly a matter for DHSC but the lack of sufficient stock of the correct items did lead to the problems above. In a similar vein, I did not initially identify testing as an area that needed commercial support and the commercial team in testing had not asked for sufficient support. Once I had addressed what I had thought was the initial priority, ventilators, I realised that testing needed more support and forced them to take more people than had initially been deployed.

27. In relation to inventory management, the obvious action is for the NHS and the larger care home providers to be forced to have viable stock management systems. However, such systems need to be in place before a pandemic. In that regard, looking at actions taken during the pandemic risks missing the point, because the ship will already have sailed. That said, it is important to be aware of the very significant costs involved in any or a mix of stock management solutions before a pandemic, as I will try to set out below.

28. Taking the issues in a logical order:

    (a) Emergency stocks. Deciding the size and content of emergency stocks is a complex trade-off, given the cost implications, and rightly a political decision. It is easy to say that 'we should have had bigger stockpiles'. Having sufficient product in stock to have been completely insulated from external disruptions for the 2 years of the pandemic, and so avoid the excess pricing we did experience, would have required massive stocks. This also assumes (a matter for clinicians) we know exactly what items we should stock, which was not the case, with the type of pandemic we had. Shelf life, which determines the rate at which stock must be recycled, also needs to be considered. Further, when medical / product development occurs, we either have to delay the introduction of the new product until existing stocks are exhausted, or we have to write off stock rendered

obsolete by the innovation. This cost can be reduced by redesigning the products to be stored to have a longer shelf life, but that typically makes them more expensive per unit; it also means the obsolescence risk is higher.

(b) One way of defraying stock holding costs is to negotiate up front with the manufacturer to hold the stock levels required. This is potentially systemically cheaper than holding the same stock in the UK, as the manufacturer can then manage the shelf life / obsolescence issues more efficiently. In practice however the risk is that the stock that was thought to be available and dedicated to (in this case) the UK, turns out not to be there, potentially as it's been sold to others. In the case of the pandemic a number of normally friendly countries also imposed export bans, so in practice the only way to be sure of the availability of such a safety stock is to have it located and managed securely in the UK.

This is not a simple exercise, and it has considerable cost consequences. Hence, it needs wide political and budgetary support, and for that support to be sustained for the entire period between pandemics, which makes it quite a challenge.

(c) Local manufacturing. An alternative to huge stock holdings is to increase local manufacturing capacity, that can be turned on when needed. The problem again is cost. As it was, we bought around 20 times pre-pandemic usage, a lot of which turned out to be surplus to actual requirements, but relying on local manufacturing still implies an investment in capacity sufficient to produce 5-10 times non-pandemic volumes. The excess capacity would sit idle, but still would need to be maintained, and as above, if new products are introduced, any such capacity would have to be updated to make the new products, for the whole period between pandemics. The same applies to any changes in manufacturing methods. If the manufacturers could sell the surplus capacity, that would reduce the costs to HMG, but what other customers would want to rely on 'non-pandemic only capacity', i.e. capacity that they would know they would be denied once a pandemic started? Even then, would their

non-pandemic costs and hence prices be competitive with manufacturers in China who are doing much larger volumes for many other countries?

(d) The manufacturing issues for PPE vary by product. By way of illustration, repurposing a bin liner production line to cut out apron shaped products rather than bin liner shaped is relatively simple, needing not much more than having a suitably designed cutting tool available. These are relatively cheap and easy to make, in a handful of weeks, and the costs of having a number of such tools available outside a pandemic 'just in case' is trivial. More complicated would be moulded products like eye googles or face shields. There are many moulding companies in the UK, so having pre-made moulding tools ready for use would enable rapid production of such things. These tools are more expensive and take longer to build – but from memory, having a set of these capable of producing very high volumes would still be less than (as an estimate) £1 million. It is tempting to think that 3D manufacturing would be an answer, but while flexible that currently is a much slower process than moulding. Anyway 3D manufacturing is not currently suitable for the two types of product that were the main focus: masks / gowns and gloves. The equipment for making masks / gowns is in a different league as regards costs and time to install. They are made from complex non-woven / melt-blown fabrics where the machines are very expensive – circa hundreds of millions of pounds in expense. The problem is not with the sewing up of the masks or gowns, but with the production of the underlying raw materials, which are made in long, wide rolls and then cut and sewn. Latex glove manufacture is similarly capital intensive, with long lead time equipment.

(e) Local supply of raw materials. As explained in paragraph 1.42 of the Corporate Statement, having local manufacturing capacity does not however increase national resilience unless you also have local (sovereign) access to sufficient supplies of the raw materials. Relying on overseas supply in an emergency should not be regarded as a safe assumption. We saw during the pandemic that other countries stopped exports of both finished products and raw

materials, so the cost of those raw material stockpiles or the capacity to manufacture them also needs to be taken into account.

(f) Securing guaranteed capacity at plants outside the UK. This is a common strategy in the private sector when surge capacity might be needed in one specific market, but it breaks down during a global supply shortage, as all the surplus capacity gets used and the contracts will frequently get broken, potentially by local governments commandeering the capacity.

29. The optimum strategy is likely a combination of the above, but the key point is that all of these are expensive. As we saw with the run-down of the 'pandemic stock' prior to this pandemic, it requires long term political and financial commitment to not only build up, but also to then store and maintain the currency of stocks over a potentially long period when it appears they are not useful.

30. I have been asked by the Inquiry about issues of "strategy and guidance" in relation to procurement, and "the expertise within government and the civil service for procurement during a whole-system civil emergency". Although pre-planning from the DHSC for procurement in the pandemic would have assisted, I do not consider the main issues for my team to have been in these areas. The existence of the GCF meant that we had broadly sufficient procurement expertise, either by deploying colleagues from across government, albeit by working day and night (as a demonstration of this, an analysis of my emails shows that, in the period from 1 February 2020 to 30 June 2020, 39% of my emails were sent or received outside normal working hours), or, in the case of Test and Trace, getting them in from external providers. However, as discussed in the Third Statement at paragraph 108, we did not have as many people as we needed in DHSC on record keeping/contract publishing. Generally, we managed to rearrange ourselves across GCF, by using the functional model as discussed at paragraph 1.39 of the Corporate Statement. Further, given the particular issues relating to procurement during a pandemic, we rapidly issued a number of Procurement Policy Notes (including PPN 01/20, PPN 02/20 and PPN 04/20) intended to supplement the foundational training and instructions that commercial colleagues would have experienced in the normal course.

31. A clear example of the rearrangements working in practice was the deployment of the PPE Buy Cell as discussed at paragraph 4.306 of the Corporate Statement. Also, on 18 March 2020, Lord Bethell asked for 25 commercial experts to be deployed on testing equipment procurement. I asked Janette Gibbs to progress this, and she initially allocated 4 of the Complex Transactions Team ("CTT") from the Cabinet Office Central Commercial teams, including Dr Jandziol (GRW/20 - INQ000471006). I also spoke directly with Emily Lawson about the deployment (GRW/21 - INQ000534488). Within a few days around 25 commercial specialists were deployed from the Cabinet Office and elsewhere in Government to form the DHSC's commercial testing team. Dr Jandziol from the Cabinet Office CTT led this group in terms of having overarching accountability and oversight and was supported by other experienced CTT commercial specialists, each working for and on behalf of the DHSC. I refer to paragraphs 4.188 to 4.189 of the Corporate Statement for further detail on the creation of this team to scale up coronavirus testing. Due to the surge of procurement problems we faced and because we simply ran out of people, even with the use of the functional model, Jacqui Rock and Marco Salzedo did ultimately need to recruit a large number - 200 or so - external people into Test & Trace.

32. I have also been asked about any issues in procurement expertise in the private sector. I am not aware of the specifics of any issues. I do not believe any such issues impacted the delivery by the private sector of public sector requirements. Generally, private sector procurement people brought into the public sector to support us were professional, but they did not instinctively understand civil service procedures or, as a consequence, the value for money controls or reporting requirements and we did not have sufficient time to train them fully. (Non-procurement consultants were used widely during the pandemic; as discussed further below, some of the related issues with that led to the publication of the Consultancy Playbook in September 2022.)

## G. PROCUREMENT DURING THE PANDEMIC

33. Details of my role in relation to Operation Moonshot and the Ventilator Challenge can be found at paragraphs 4.251 to 4.260 and 4.1 to 4.152 respectively of the Corporate Statement.

34. As described in relation to the Ventilator Challenge, during the pandemic, there was a focused appeal to industry for help in respect of ventilators which worked well. In comparison, the "calls to arms" for PPE (and the publicity around lack of PPE), as described at paragraph 31 of my Third Statement, generated thousands of leads, most of which did not prove fruitful.

35. A main issue in the procurement of key healthcare equipment and supplies during the pandemic was with what in the commercial world would be known as "S&OP" – sales and operational planning – and the lack of it as it pertained to the items we needed during the pandemic. The difficulty experienced in forecasting demand was probably the single largest issue. Had the true level of demand been forecasted before the pandemic, we might have had the right levels of pandemic stock, and we would thus not have been in an immediate shortage position. It was the almost immediate shortages which then (understandably) caused such a risk averse reaction that led to over-ordering, which then generated the second order problem of having to commit to longer term orders, (which in a seller's market was very expensive) which compounded the over-buying. The demand however was set by DHSC and others, and my team did not have sight of the scale of over-buying until late on.

36. Further, not having a rapid or accurate feedback loop for PPE meant that we did not react fast enough to slow incoming volume, leading to the excess stocks that then had to be written off as shelf lives expired. However, it must be appreciated that forecasting demand was very difficult, especially at the beginning of the pandemic when data was scarce and when the significant procurement activity was undertaken. I understand the forecasting assumed very significant growth in patient numbers and therefore huge growth in demand. In reality, patient numbers flattened, and doctors started re-using equipment, such as eye glasses or other PPE equipment.

37. Had the NHS had any, or better, systems for knowing what stock they had on hand, and what the usage rates actually were, then it is likely that the teams (McKinsey and Palantir in support) specifying the volumes they required purchasing to buy would have been more alert to changes in usage and might not have asked for so much to be bought. I never dealt with McKinsey directly and the procurement teams were not in a position to debate volumes but were required to buy what they were told to buy. I do acknowledge that this is all

easy to say from an outside perspective, but I know it is not an easy thing to know how much stock is actually being used and it usually takes years to put a stock control system in place.

38. If there had been better and faster reality checking against actual usage of PPE and incoming delivery schedules, it could and should have led to cancellations. When sickness levels reduced and it became clear that usage levels were far below those originally predicted, e.g. for eyewear that clinical staff were reusing, we could have acted faster to reduce or cancel orders already placed as above, before they were delivered. As flagged in paragraph 114 of my Third Statement, when the overbuying of PPE became clear, I wrote to David Williams and colleagues on 28 November 2020 to flag this in a note entitled: "*When is money for nothing a good idea .....*" (GRW/22 - INQ000528238). My point was that, if we have too much on order, it is better to cancel orders or compensate the supplier for what they have spent, even adding a cancellation charge or related profit margin, rather than let them continue buying raw materials, manufacturing product, injecting costs, then transporting it, further injecting costs. In that way, 'money for nothing' was better than 'more money for something that we knew would go in the bin' (GRW/23 - INQ000534526). Paying such cancellation fees for no outcome is very countercultural for government, probably counter to "Managing Public Money" and would raise concerns as to how to approve and communicate such a decision. However, it would nonetheless, if aggressively pursued, have saved considerable sums.

39. A similar situation arose with antiviral tablets (Projects Tyne and Arrow) in September 2021, where we ended up spending, from memory, around £1.5 billion, on a product that was scarcely used (GRW/24 - INQ000534543 and GRW/25 - INQ000534540). That contract was put in place without as far as I am aware any internal commercial support at all from within DHSC (GRW/26 - INQ000534534; GRW/27 - INQ000534535; GRW/28 - INQ000534537; GRW/29 - INQ000534536; GRW/30 - INQ000562821; GRW/31 - INQ000562819; GRW/32 - INQ000562820). The team responsible relied on external consultants, who, while good, were not integrated with the rest of the DHSC commercial team. Two orders were placed, with the argument being that if we did not buy it, someone else would. However, the issue could have been avoided by, for example, buying quarterly or by having a postponable delivery date.

40. Balanced against that of course was the desire of health ministers, officials and the public not to run out of any product at all. As in paragraphs 4.331 and 4.494.1 of the Corporate Statement, operating to even a Reasonable Worst Case Scenario will likely always (if the RWCS fortunately does not materialise) result in overstocking as overstocking is seen as a lower cost to the system than the outcome that is being protected against.

41. The end result of the wider PPE acquisition process was that we bought much more product than we actually required (GRW/33 - INQ000528239), albeit at the time that was not evident (GRW/34 - INQ000534502). As explained in paragraph 4.494 of the Corporate Statement and above, this was to some degree inevitable. The underlying forecasts flowed from estimates of stock levels, which were highly uncertain, and from anticipated usage rates of the product which given the extended delivery times for the product (from China) were even more uncertain, as at the time of order there would have been significant uncertainty as to the extent of the growth in usage volumes that would be experienced by the time of the order's delivery.

42. I also refer to the following paragraphs of the Corporate Statement which discuss issues in the structures, processes and procedures for the procurement of key healthcare equipment and supplies during the pandemic:

    (a) paragraph 1.23 where I explain the lag between buying decisions being taken and product availability;

    (b) paragraph 1.28 which explains the restricted ability to inspect goods before arrival in the UK;

    (c) paragraphs 1.29, 1.35 and 3.32 where I discuss delay in publishing contract award notices;

    (d) paragraph 4.380 details in-country inspections for a small number of contracts;

(e) paragraph 4.381 covers the issues with obtaining samples to inspect in advance; and

(f) paragraph 4.510 explains the situation in relation to the inspection of goods.

43. I also refer to the final paragraphs of my Third Statement which touch on:

(a) paragraphs 85 to 87 where I discuss the impact of the lack of PPE and the collapse of global supply chains;

(b) paragraph 107 where I discuss the disadvantages of a 'call to arms';

(c) paragraph 108 where I discuss the delay in publishing contract details; and

(d) paragraphs 114 and 116 where I discuss the deficiencies in stock planning and management.

## H. THE APPROACH TO INDUSTRY ENGAGEMENT

44. The aim when engaging with industry in the procurement of key healthcare equipment and supplies was to secure appropriately approved supply or sources of supplies as rapidly and effectively as possible while operating within the appropriate regulations. The normal focus on due process and value for money had to be balanced with the need to procure sometimes novel goods and services extremely rapidly in overheated markets. For instance, in the Ventilator Challenge, a Cabinet Office team from the GCF worked with industry on firstly designing and then manufacturing new ventilators. I was the Senior Responsible Officer (SRO) for this project and (delegated from the Cabinet Office Permanent Secretary) the Accounting Officer.

45. My own direct engagement with suppliers of key healthcare equipment and supplies was as already set out in the Corporate Statement in relation to the Ventilator Challenge. In relation to tests, there was a clear mandate from the Health Secretary and the Prime Minister to scale up coronavirus testing. This

would inevitably require involvement of companies that manufactured the machinery and chemicals used for the then current testing method – principally PCR testing. Given the huge increase in demand, it was important to identify and then scale up, if possible, reliable tests that were any or all of: faster (to give a result) or cheaper or manufacturable in greater quantities. The investigation, let alone delivery of that would not have been possible without 'direct engagement'. My part in the search for the above was, as described further in my Third Statement, to visit:

(a) the Milton Keynes and Glasgow 'Lighthouse' labs, where I discovered that the labs were typically not running most of Sundays and Mondays due to lack of sample supply;

(b) Mologic, a supplier of antibody tests that was developing (though failed to) an antigen LFD where I also met the Managing Director of Flex-tronix who were, funded by the Bill Gates Foundation, trying to come up with a very high volumes of flexo-printed, and hence cheap, tests that would achieve the same aims as the LFD product;

(c) Oxford Nanopore, who had a new and interesting technology for analysing DNA / RNA; and

(d) LurimaDx, which I visited with Chris Hall initially, the most promising of these (GRW/35 - INQ000528231).

46. Both (c) and (d) were run by ex Medisense directors, Medisense being the company that brought the first diabetes testing strip technology to the UK market, and so they knew what was needed to be successful. (I had knowledge of this as I had a background in printing technology and had run Medisense's strip supplier.) LumiraDx's line was very impressive and capable of producing almost all of our needs, but their product did not, during the time I was involved, demonstrate the sensitivity required by Porton Down.

47. Mologic was a developer of lateral flow and rapid diagnostic technologies. I was initially connected to Mologic through Dr Emma Stanton of the DHSC on 22 September 2020 (GRW/36 - INQ000534519) and I engaged with them because they were already a supplier of antibody tests and so were an obvious potential

source of antigen tests. I visited their facilities on 25 September 2020 (GRW/37 - INQ000528225). Dr John Rippeth of PA produced a review of Mologic following that visit (GRW/38 - INQ000534520; GRW/39 - INQ000534521; GRW/40 - INQ000528230).

48. Oxford Nanopore was a developer of DNA sequencing technology, used to sequence Covid. I was also connected to Oxford Nanopore by Dr Stanton on 22 September 2020, and I engaged with them because Dr Stanton suggested it. Accordingly, I visited their facilities and, on the same day, those of UK Biocentre, as a number of their senior staff had been central to the development of one of the original pregnancy testing strips (GRW/41 - INQ000534518 and GRW/42- INQ000528232).

49. LumiraDx was also a developer of Covid and other tests. I visited LumiraDx's facilities on 2 November 2020 with Chris Hall, likely on Chris' or another colleague's instigation, where we saw their reel to reel, high volume production line (GRW/43 - INQ000534523). I also had calls organised with those at LumiraDx on 13 December 2020 (GRW/44 - INQ000534528) and 8 January 2021 (GRW/45 - INQ000534529).

## I. OVERALL VALUE IN THE CONTRACTS AWARDED

50. The decision of what to buy, to satisfy which need, is one for each department and contracting authority to take for itself. Each department has an internal process for assessing its external spend proposals and amending / approving them internally. Those have similar steps but are inevitably slightly different from one department to another. Those processes are audited by the Government Internal Audit Agency ("GIAA") and the National Audit Office ("NAO") etc. I cannot comment on the effectiveness of those departments' internal audit processes. Each department is also responsible for managing its contracts in order to drive value for money and contract performance. To support the professionalisation and skill of departmental contract managers, the GCF has developed a number of highly regarded training courses that continued to be taken up during the pandemic, with the aim of driving up the value delivered by a department's contracts. In particular, the GCF set up training on contract management aimed at three levels of proficiency. At May 2020, 6,500 had been accredited at foundation level and 235 trained and 69

accredited at Practitioner & Expert level. By May 2022, 13,459 had been accredited at foundation level and 367 trained and 134 accredited at Practitioner & Expert level. These numbers show the level of improvement already developed in this skill set at May 2020 and the continuing improvement during the pandemic. In addition, in April and May 2020, the GCF delivered 50 web classes to address pandemic related issues across 8 subjects, the most popular of which was "The Fundamentals for a Crisis Situation & Risk Management: On-boarding suppliers or contracts at pace", given to approximately 3,200 attendees across the public sector (GRW/46 - INQ000534481).

51. The Cabinet Office per se did not procure a meaningful volume of healthcare equipment or supplies, with the exception of ventilators and some mask making machines. In relation to the selection and procurement of ventilators, a Technical Design Authority was set up which included a panel of clinicians, led by Professor Ramani Moonesinghe, supported by independent staff from PA Consulting to determine 'what' was being bought. To control how much was paid for that, vendors were contracted on the basis of reasonable and provable costs during the design phase, and, if their design was subsequently manufactured, they were paid for the volume they produced on a piece part basis with open book costs plus an agreed profit margin. The costs submitted by each vendor were checked by a member of the PA Consulting and Cabinet Office teams, overseen by a team from CASS, the cost control team within the Ministry of Defence. The overall cost of the ventilators built compared favourably with the market price for existing products. There was no time to run formal competitions such as under the seldom used Innovation Partnerships or the more frequently used Competitive Dialogue procedures (I address this further at paragraph 105 below). However, the 'TDA down-select' mechanism adopted is very similar in concept to the Innovation Partnerships methodology. The NAO audited the overall costs of the program – some £330m - and produced a report on it dated 30 September 2020 (GRW/47 - **INQ000087456**).

52. In relation to the procurement of PPE, as described in the Corporate Statement at paragraphs 4.451 to 4.454, there was no time to run formal competitions. The team used price comparisons of the offered / negotiated price compared to recent experience to assess whether a price was reasonable in the extreme circumstances at the time. After the initial very sharp rise in prices due to the

huge imbalance of supply and demand as discussed, pricing during the main buying period flattened out (GRW/48 - INQ000528246), albeit at a very high level, making this approach reasonable. The PPE Cell team doing the negotiating was separate from the committee within DHSC (who were the contracting authority and were thus responsible for determining what constituted 'value') that took decisions on whether to accept the negotiated price. It was recognised by all at the time that the prices being paid were far in excess of the pre-pandemic market price given the shortage of supply and the vast worldwide demand.

## J. SPENDING CONTROLS AND FUNDING

53. The Cabinet Office would not normally have expected to be kept in touch with month-to-month spending levels within a department. HM Treasury ("HMT") sets the budgets and controls for a department, and within those limits the department will look to let contracts for whatever goods and services it determines it needs. The Cabinet Office role, through the commercial assurance team, is to ensure those contracts reflect best appropriate commercial practice.

54. I have been asked by the Inquiry about funding envelopes for PPE, testing kit and equipment, ventilators and oxygen. In respect of the funding envelope for the Ventilator Challenge, I indicated an approximate spend of £2 billion to John Manzoni but it was a colleague, perhaps Rick Hornby, who conducted the discussion with HMT that led to the allocation of what turned out to be c.£350m (GRW/49 - INQ000562815). I was not otherwise involved in funding envelopes for any key health equipment and supplies.

55. I was involved in some discussions about spend control mechanisms when it came to PPE. I recollect that there were discussions in April and May 2020. It was my view that the spending control process should be regularised but in a way which did not add delay or unnecessary extra processes to the PPE procurement process (GRW/50 - INQ000562816 and GRW/51 - INQ000534505).

56. I have also been asked by the Inquiry about spending by DHSC. I do not know if DHSC were effectively monitoring their inventory and expenditure. My only

interaction where I was aware of DHSC stock situations was with antivirals where it was clear that stocks and incoming deliveries were very far in excess of usage.

57. I am unaware whether DHSC was operating within its control totals (that being a matter between them and HMT) but would comment that the spend estimates from Test and Trace fluctuated very wildly, far outside the range anyone would expect of any mature organisation. Their initial budget for 20/21 was I believe some £15bn and I believe they asked HMT for an extension to £22bn, reluctantly conceded (GRW/52 - INQ000534525; GRW/53 - INQ000534525). As at mid-March 21, with only a few weeks before the end of the year, and indeed in early April, after year end, they were still estimating they were in that £22bn range (GRW/54 - INQ000534531). I believe they came in at £14bn, (GRW/55 - INQ000534532) a delta of £8bn, which I recall a senior HMT official reminded everyone was more than the annual budget of the whole of the Ministry of Justice and its arm's length bodies. So, while I did not have direct influence over it or knowledge of it, I would have significant doubts about whether Test and Trace was managing to adhere to any conditions imposed upon spending levels or to effectively monitor inventory and expenditure. The changes to DHSC's spending limits are set out at paragraphs 4.241 to 4.246 of the Corporate Statement.

58. The commercial Spend Control System in relation to equipment outside of PPE and vaccines, described more fully in paragraph 1.46 of the Corporate statement, worked well and made meaningful suggestions and where appropriate placed conditions on approval that drove better contract terms and / or pricing. This was not a competitive or adversarial process, but one intended to act as the final line of assurance, adding expertise and advice for the benefit of the contracting departments.

59. Pre-pandemic there existed a system of controls over commercial contracts – see the Corporate Statement at paragraphs 2.26 to 2.28 where the Cabinet Office commercial assurance team would, with the relevant department, identify (from those contracts anticipated to be over a certain value, such as £10m, depending on the contract type) the 'novel, contentious, repercussive' proposals and look further at them (with the rest being left to the department to 'self-assure'). Around 1/3 of the total cases were called in, of which around 1/3

were written up for discussion with the minister. The assurance was to assess 'how' something was being contracted for. It was not to assess 'whether or not' a department needed the thing in question, that being for them and their minister. However, as previously described, there is necessarily a delay at the end of a procurement process while this is done. The response time service level agreement was 28 days, but the actual turnaround time in early March 2020 was an average of 18 days (GRW/56 - INQ000534542).

60. At that time, the controls process only applied to central government departments. The NHS was outside that system until at least October 2022, so I can make no comment on NHS spend outside of what was bought by DHSC and Test and Trace.

61. During the pandemic time was precious, which is why the HMT and then the Cabinet Office Minister, Lord Agnew, agreed that PPE contracts should not come to the controls panel. Lord Agnew also widened the group who came to the control's meetings to include digital and HMT colleagues. This was a good step as it allowed a wider discussion of the merits of the approaches being taken in those control cases.

62. Of the major categories of equipment, the effectiveness of the commercial control processes in relation to ventilators was excellent, and as above PPE was out of scope. In relation to Test and Trace procurement, the effectiveness was variable to poor. This was partly because what they were looking to acquire almost constantly changed, as for example the requirements for larger and larger number of daily tests mushroomed, which affected the numbers of people needed on test collection sites as well as the volumes that should be processed by the labs, but also because in an attempt to reduce the time taken to do the assurance, so as not to delay acquisition, the central team was often talking direct to Test and Trace, on occasion ahead of formal approvals within DHSC. Consequently, time was several times wasted on assuring items that DHSC ministers then amended or rejected. While potentially only a minor point, it would have been better to do all the steps of this type of multi-level assurance in one process, with all interested parties at the table at once, but the reality is that frequently DHSC colleagues were too swamped to be able to do that. At times, I was involved in discussing with Test and Trace whether there were

ways in which companies other than Innova were able to get their product qualified faster and on the assurance conditions placed on certain orders and assisting them in understanding and meeting the spirit of those conditions (GRW/57 - INQ000534530).

63. As above, the central commercial assurance process only applied to contracts of over certain values. Contracts below that are left to individual departments to self-assure. Early in the pandemic a number of small contracts were awarded by the Cabinet Office, acting for No10, for media contracts. These were the subject of judicial review by the Good Law Project (GLP) where it was found that the decision to award was lawful (GRW/58 - INQ000534538). However, it was clear that multiple changes were needed to improve the Cabinet Office's local processes for handling such contracts. These are the subject of the Boardman 1 report, following the publication of which all of the recommendations were being implemented.

64. Generally, a balance had to be struck between getting as good a contract as we could, and acting swiftly enough to actually buy the product or service. Purchasing was often done in response to what was frequently an urgent and unforeseen demand, often coming from a team who would advertise that 'they had been set up specifically by the Prime Minister'. An example was the urgent requirement, discussed above, for, initially, £11bn of antiviral drugs, which came unexpectedly from such a group located within DHSC, the Antivirals Taskforce. This is a good example of where commercial expertise was brought to bear to reduce HMG's exposure (to some £1.5bn), despite the overt pressure from that team for an immediate contract. It would have been better if DHSC's commercial staff had been aware of the project, and if the normal process had been engaged much earlier as I believe that would have further reduced the cost to HMG significantly, but the assurance system did 'catch' even this unanticipated requirement and protect taxpayer's money to a considerable extent.

65. Generally, the assurance panel's advice was taken, and the conditions of approval followed. However, in Test and Trace, we had a few situations where they were looking to contract for outsourced call centre support. Under the initial contracts they only ended up using a small fraction of the capacity installed. For subsequent contracts, we asked that they contract for lower

volumes, but with an added commitment from the vendor to be able to rapidly ramp up (or down) their available capacity up to a maximum rate, at the Test and Trace's request (GRW/59 - INQ000534527; GRW/60 - INQ000534522; GRW/61 - INQ000534516). This seemed like a sensible approach to minimise costs while still allowing for sufficient flex in staffing levels. In the event however, Test and Trace repetitively triggered the ramp conditions, building capacity again, thus reducing capacity utilisation to, from memory, c1%, and consequently dramatically overspending, even allowing for a sizeable buffer to protect against expected and unexpected surges in demand.

66. In relation to ventilators, I refer to paragraphs 4.137 to 4.141 of the Corporate Statement. HMT agreed a funding envelope for the ventilator package, which was twice increased.

## K. STEPS TAKEN TO ELIMINATE FRAUD AND THE PREVALENCE OF FRAUD

67. Details of counter fraud measures are found at paragraphs 5.1 to 5.52 of the Corporate Statement. For PPE there were separated steps and separated teams to minimise the risks of fraud or maladministration. The PPE Buy Cell (including the HPL) instituted its multistage mechanism to guard against the possibility of bad behaviour by officials, with different people signing off on the segregated stages of every deal that went through. DHSC will have details of how they identified and pursued potential instances of fraudulently misrepresented PPE. The PPE Buy Cell and the HPL have been addressed in my Third Statement.

68. My experience of counter fraud measures in relation to procurement during the pandemic was good given the circumstances. They were adapted during the pandemic as set out at paragraphs 5.18 to 5.52 of the Corporate Statement, including the tightening of the oversight of new vendors by DHSC banks. DHSC also had a team working on situations where product was not delivered after payment or was defective, as set out at paragraph 74 of my Third Statement.

## L. CONFLICTS OF INTEREST

69. At paragraphs 3.57 to 3.87 of the Corporate Statement, I have set out the codes of conduct, regulations and guidance which apply generally and in respect of conflicts of interest. Further, as set out at paragraph 3.92 of the Corporate Statement, on 27 July 2022, the Cabinet Office published specific guidance on 'Principles for Ministerial involvement in commercial activity and the contracting process'. Drafting of this guidance had begun by 23 April 2021 at the latest (GRW/62 - INQ000534533).

70. Industry wishes to sell products or services to government and part of our job is to ensure that if government wants those products or services, a process is used to assess the potential contract and keep people with conflicts out of the decision chain.

71. I am very confident that I have no involvement with any of the companies mentioned above, and so there was no actual conflict in my talking to them. Had there been, I would have declared it, and then I would have been taken off / would have taken myself off the decision-making team.

72. The GCF team came into Test and Trace after the initial lab contract terms were agreed, especially those with Randox, so I cannot comment on those. However, some general comments, as provided in the paragraphs below, are I hope helpful.

73. In the event, with each of the Test and Trace companies I was in direct contact with (as described at paragraph 45 above), I was not in the decision-making team, and regardless, the principal hurdle they each had to clear was having a product that worked consistently in the eyes of the experts at Porton Down, who rightly operated independently. I would imagine (but do not know) that they also have a multi-step process, with different people in each step, like we instituted for the selection of PPE, that all but eliminates the possibility of anyone with a 'conflict', even an undeclared one, being unilaterally able to affect a decision. Further, it was well publicised that we were looking for tests of all sorts, and my involvement or the involvement of other colleagues in engaging with one or other company did not prevent others coming forward themselves and submitting product. Regrettably none of those products from the companies I visited passed the Porton Down sensitivity tests required so the point is moot.

74. The Inquiry has asked how actual and potential conflicts of interest can be avoided. It is important to be clear what is meant by a 'conflict of interest' and who should avoid it. In terms of whether there are ways of avoiding a conflict 'in the moment' of engagement,' or whether 'potential conflicts should be avoided', let me deal with each in turn, looking from the perspective of the different groups of possible players:

(a) Suppliers. Anyone working for a supplier does not have a conflict of interest; it's much stronger than that - they have an interest! Self-evidently they will try and influence the specifying / buying team about the 'standout merits' of their product and the superiority of their offer. Recording any information on who suppliers know who might be involved in the decision-making process is however borderline pointless - it is not only very hard to police, but as their job is to meet as many people from the buying entity as possible, keeping such a list up to date is borderline impossible.

(b) Buying side – including people who draft the specifications of the product that will be bought. Here there may be conflicts, and they should be declared; for example if anyone on the buying side, who will be involved in shaping a decision, has any links to the sales side that could influence them to take a biased decision or make a biased assessment of a facet of an offer; e.g. a relative working for the supplier, or a financial stake in the supplier or one of its relevant competitors, these should be declared as soon as an interaction starts.

75. We should be realistic about what can be declared in advance of knowing that you are going to meet a specific supplier and engaging with them. Financial investments are reasonably easy to record, but even there it is not so simple; for example, does the average person know exactly what their pension is invested in or who those companies compete with? So, materiality has to come into it. Looking therefore at:

(a) Actual versus potential conflicts: it is not possible to list all the companies that anyone has a friend or even a relative working at that

might in future generate a conflict; consequently, the onus is on the buying team member to declare the conflict as they start to look at specific new companies as soon as it becomes apparent.

(b) Avoiding potential conflicts: it is very hard to keep a complete list of potential conflicts although obvious ones could be listed. The key is to identify when a potential conflict becomes an actual conflict. For example, everyone would have potential conflicts with multiple companies, at for example the places they used to work; there is no way of avoiding those ex-ante, that potential for conflict already exists. The question is do they become real conflicts, which is only knowable when one of those companies appears as a potential vendor. Also, a buying team member could be working on a bid from a vendor, with no conflicts, when out of the blue their (for example) ex-partner goes to work for that vendor or one of its competitors. In the moment before they sign up there is a 'potential' conflict, albeit unknowable and not usefully documentable, but only after they have signed on, is there an actual conflict, which should then be declared. We have procedures in place that require these actual conflicts to be declared (see further below). From these examples hopefully it can be seen that everyone has 'potential conflicts' with vast numbers of entities. Extending the above examples, no one knows where their siblings or partners might potentially go and work or in where they might invest. All of which is to say that it is unreasonable to expect 'potential conflicts', if taken literally, to be "avoided". It is important that procurement teams and anyone associated with procurement decisions are aware of 'potential conflicts'. Actual conflicts are another matter – they should be declared. Further, actual conflicts, once declared, would normally be resolved by taking such people out of the decision making team.

(c) Other Intermediaries / Ministers: The PPE press coverage has raised this, and the GCF has modified its procedures and guidance (Principles for Ministerial involvement in commercial activity and the contracting process, published on gov.uk on 27 July 2022: GRW/63 - INQ000471040) to cover an area that has generated a lot of concern. This is to be welcomed, although it does not seem that the

level of concern derives from any actual cases of decisions being taken by people with a conflict, declared or undeclared. The NAO commented in their PPE report of 26 November 2020 that 'we found that the ministers had properly declared their interests, and we found no evidence of their involvement in procurement decisions or contract management' (GRW/64 - **INQ000234626**). I hope that the description of the PPE process in paragraphs 4.456 and 4.461 to 4.468 of the Corporate Statement has demonstrated how and why that was the case for PPE, and how the "TDA" selection panel used in the selection of ventilators was independent. Nonetheless it is important that we can be seen to be completely transparent, and so the guidance now requires Ministers to declare conflicts they do have, not just as previously, when they take office, but also should they meet or have contact with individual companies on specific procurements they should now declare whether they have a conflict with that specific entity. As above, that is only doable when the specific case is known.

76. It is important to note, however, that the conflicts declarations are truly important only from those staff directly involved in the decision to go with A rather than B or C. Commercial colleagues who handle other aspects of a case but are not part of the decision-making group are less of a concern, though, as described at paragraph 3.83 of the Corporate Statement, all departmental GCO staff (who are the ones deciding on contracts) should complete a conflicts form.

77. Further detail on how conflicts of interest are handled is at paragraphs 3.57 to 3.103 and 7.71 to 7.35 of the Corporate Statement.

## M. CONTRACTUAL PROVISIONS AND PERFORMANCE BY SUPPLIERS AND MANUFACTURERS

78. The GCF had, pre-pandemic, put in place a number of standard contract templates, including the suite of Model Service Contracts; and these were and are continually updated. They are for use by any public contracting authorities. Departments often take those and adapt them for their own specific purposes, so in reality there is no totally 'common' contracting template used across even central government. Each contracting authority is responsible for its own

contracts. Given the variety of items bought, there is a variety of standard terms embedded in each. For example when buying not services, but the products that the Inquiry is primarily interested in, the testing and acceptance processes for specific products will vary across different types of product, e.g. laptops or drugs. That said, the Commercial Policy team in the Cabinet Office issues guidance on what areas should be covered in those terms, and at the beginning of the pandemic issued guidance as to how contracting authorities should react to the issues posed by the pandemic. I referred to PPN 01/20 at paragraphs 3.40 to 3.47 of the Corporate Statement.

79. The negotiation of contractual terms which provided suitable protection to the government was limited by the 'sellers' market' situation for several categories during the pandemic. For example, clauses such as paying up front for PPE rather than paying on receipt are ones that would not normally be accepted. I also refer to paragraph 4.455 of the Corporate Statement and paragraph 74 of my Third Statement in respect of advance payments. Equally, although in some contracts the team were able to introduce break clauses, vendors were in a stronger position than normal to reject clauses that would have allowed for early cancellation or amendment of volumes.

80. It is tempting to think that having pre-arranged framework agreements in place would have allowed us to avoid much of the pricing excesses or to be able to rely on pre-agreed terms and conditions. Regrettably this is not the case; if the maximum pricing built into the framework when it was let then turned out to be much lower than the market at the time of the call off – i.e. the circumstances of the pandemic – then the vendor just wouldn't bid (frameworks rarely require every participant to bid on every call off). Even if the framework did have that requirement, a vendor could easily avoid a contract by bidding for example, a ridiculously high price, that would never win the contract. Additionally, bidding for multiple frameworks, or even lots within frameworks, that aren't then used, also injects costs for bidders that they wouldn't be able to recover, and therefore in the absence of a belief that the pandemic volume will be asked for, those unrecovered bid costs would potentially deter the very bidders we are wanting to attract.

81. Redress regarding contracts where the vendor had failed to deliver was the responsibility of DHSC or the NHS (GRW/65 - INQ000534539). It was handled

by a team they set up for this purpose, with whom I interacted. My view, as above, is that cancelling PPE contracts or antiviral contracts, when it became clear we were buying volumes far in excess of what I had come to believe the reasonable worst-case scenario called for was too slow.

82. In respect of the effectiveness of the above procedures during the pandemic and adaptions made during the pandemic, I refer to paragraphs 3.40 to 3.50 of the Corporate Statement.

## N. PUBLIC LAW PROCUREMENT PRINCIPLES, REGULATIONS AND GUIDANCE

83. All procurement staff are trained in procurement law, and the constraints on processes and actions that that places on them compared to the private sector. As described in the Corporate Statement at paragraphs 3.14 to 3.26, the pre-existing Public Procurement Regulations contain clauses covering the procurement of items in an emergency – known widely as 'Reg32'.

84. As above, the central Policy Team issued guidance throughout the pandemic to accentuate the key aspects that contracting authorities should take account of and adhere to.

85. The appropriate use of 'Reg32' revolves around what is or is not 'a foreseeable' event. On occasion, where I considered its use was not justifiable, I raised concerns about such use of Reg32, (GRW/66 - INQ000471019) for example as described at paragraph 4.221 of the Corporate Statement. A number of external challenges were received, not from vendors, but from bodies such as the Good Law Project, who challenged on that and other bases (GRW/67 - INQ000477966). I also refer to paragraph 4.421 of the Corporate Statement which details the Court's response to one such challenge.

86. The most relevant guidance for procurement issues during the pandemic was the body of procurement policy notes that surround the Public Contracts Regulations 2015.

87. The Inquiry has asked about the Outsourcing Playbook. However, the Outsourcing Playbook was not the most relevant guidance. The Outsourcing

Playbook was the first in the series of Playbooks, which formed part of the wider set of best practice guidance issued by the Government Commercial Function. It addresses the way in which government and suppliers should interact to best mutual advantage for outsourced services. It built on the February 2017 "Supplier Code of Conduct" (GRW/68 - INQ000534482) for which I wrote the foreword. I was then the sponsor for the Outsourcing Playbook, for which Sir John Manzoni was the signatory of the foreword in February 2019 (GRW/69 - INQ000513561). However the work was done initially by the team working for Conrad Smewing when he was a Deputy Director in HMT and then taken over by Clare Gibbs (now director of the Markets and Suppliers team), and Meryl Bushell, one of the senior Crown Reps. One of my roles as sponsor was to ensure that industry was fully engaged in the working sessions, but also at the senior review meetings that were held regularly during its compilation and after launch.

88. The Outsourcing Playbook was generated, with industry, following the collapse of Carillion. This was not because any of the outsourced contracts with Carillion were not delivered, even after the company collapsed, but because of the opportunity Carillion's collapse gave us to look at a problematic area, namely how government contracts for, and then manages, what are termed 'complex outsourcings'.

89. 'Normal' outsourcing is the activity of getting third parties to undertake services, typically such as building security, catering or cleaning or IT provision delivered up to that point by in-house teams. The underlying theory is that, as there is a wide market for third party provision of such services, all customers can benefit from the scale economies that the size of the market offers external providers, so both customers and providers can operate more efficiently and cost effectively.

90. By contrast, 'complex' outsourcings are defined as those where government is the only customer, such as the provision of the rehabilitation of prisoners, the management of outsourced prisons, the detention of asylum seekers etc. For these 'complex' outsourcings, there is no pre-existing third party market that brings scale economies. So the benefits derived flow from how well the provider manages the contract compared to the customer's in-house management. Where they work well, they can be very successful. Where they go wrong is

often because of poorly defined outcomes or inappropriate risk transfers. The Outsourcing Playbook has been a huge success, hailed by industry as a big step forward on how such contracts are handled.

91. However, in the context of procurement of healthcare equipment and supplies in the pandemic, it is important to highlight that the Outsourcing Playbook was written for the outsourcing of services especially, as above, for services for which the Government is the only customer, rather than for the buying of products or goods. The items that were particularly relevant to the pandemic, such as PPE, were products not services, and consequently many of the 11 principles in the Outsourcing Playbook, while correct in their context, are not relevant. Therefore, the Outsourcing Playbook was not relevant to responding to many of the procurement issues that arose during the pandemic.

92. The possible exceptions to that are the Lighthouse Laboratories (which were a service) and the large consulting contracts awarded by Test and Trace. However, as stated elsewhere, the original deals were agreed to by non-commercial staff (before sufficient commercial professionals were in place and or properly empowered) within Test and Trace, who would probably not have been aware of normal commercial practice or the Playbooks. By the time that the Lighthouse contracts came up for extension, there was more commercial capability within Test and Trace. In July 2020, a request was made for the expansion of the capacity of the Lighthouse Laboratories at a cost of over £1.1 billion. Each of Lord Agnew, Alex Chisholm and I raised concerns on the request, including, for myself, in relation to the proposed use of Regulation 32 (GRW/66 - INQ000471019; GRW/70 - INQ000534512; GRW/71 - INQ000534513). Baroness Harding was operating under direct instructions from the Prime Minister in respect of the request and we were trying to get the best commercial deal we could in the very limited time available in what was a highly political situation (GRW/72 - INQ000534515; GRW/73 - INQ000534514). The subsequent escalation and resolution to this matter is discussed at paragraph 4.221 of the Corporate Statement.

93. Much of the drive to write, with industry, the subsequent 'Consultancy Playbook' (published on 5 September 2022) stemmed from issues seen when contracting with consultants, during Covid. In particular, the Consultancy Playbook calls out the need to ensure that engagements are time limited and

that specific deliverables, timescales and outcomes are pre-defined. It is too easy to fall into the trap of using external consulting firms purely as a source of contingent labour. When that happens, it becomes in the consulting firm's interest to 'land and expand', leading to increasing numbers of external staff on site. The playbook also talks about the need for strong contract management and governance which when absent leads to poor value for money and lack of delivery.

94. As above the PPN process allowed for communication of how the pre-existing regulations should be interpreted and implemented within the existing flexibilities the PCR contained. The PPNs were adopted across government and, in particular, the one concerning changes to performance condition assessment was successful at enabling contracting authorities to intelligently assess contract delivery of services that had been curtailed. Successful efforts were also made to ensure prompt payment of invoices by public contracting authorities, at a time when companies cash flow was severely damaged.

95. Beyond that it should be recognised how long it takes to change underlying regulation. The Procurement Act 2023 was enacted on 26 October 2023 and will now come into force in February 2025. Internal work had begun on this several years before the pandemic, leading to the first meeting of the external advisory group on the 24 October 2019, which kicked off the process of wider consultations (which ended in December 2021 with over 600 responses), which in turn led to the subsequent drafting work and consequent parliamentary processes. There was no time during the pandemic to bring about faster changes to the regulatory regimes, and I do not believe parliamentary time would have been allocated to it, given the other legislative pressures, even had officials been able to move faster.

## O. DECISIONS AS TO WHAT TO BUY AT WHAT COST

96. Purchase requirements were defined by clinicians and the quantities needed were rightly defined by ministers and, on occasion, the PM working with the NHS / DHSC on PPE or on Test and Trace. Neither what is being bought or in what quantity should normally be for the procurement teams to determine. Effective decision-making on costs of purchases was achieved by trying to generate a market or competition wherever possible and where time allowed.

As stated in the Corporate Statement at paragraph 4.453, time constraints did, in many of the cases the Inquiry is interested in, preclude 'formal competitions'; but that does not mean that the use of Reg32 precluded running, as was done, informal competitions (such as the Ventilator Challenge which was an ad hoc competition based on meeting a published specification similar in concept to the formal 'Innovation Partnership' procedure) or from comparing prices in the market to build 'informal competitions' (such as in relation to food parcels / consultancy services / provision of apps: (GRW/74 - INQ000534501; GRW/75 - INQ000561912; GRW/76 - INQ000561913; GRW/77 - INQ000561914; GRW/78 - INQ000562822; GRW/79 - INQ000561915; GRW/80 - INQ000561916; GRW/81 - INQ000561917).

97. The local processes for assessing the quality of incoming products or services received are for the department ordering the requirement to determine.

98. With the exception of the process on ventilators, as described, I had no role in the process around setting of specifications or volumes or assessment of appropriate costs. However an incident where accidentally the wrong masks were bought made me realise, when they were delivered, that, for an inexperienced buyer of PPE the specifications of the masks (as bought from Ayanda) were unclear (see the Corporate Statement at paragraph 4.496). I also became aware of issues that the PPE Buy Cell experienced where there was room for confusion as regarding packaging specifications. I recall that, after the first few weeks, the NHS did provide contact details for two senior nurses to the PPE Buy Cell who could be contacted to discuss specifications but the specifications were not a matter in which the Cabinet Office had any role.

99. To protect against similar issues in future pandemics it would be worth investing time to ensure specifications could be interpreted correctly by non-experts, as we should anticipate that surge resources will again be needed. Also a good system should be in place to ensure any changes to a specification are correctly disseminated to everyone involved in procurements. This is not least so that quality assessments on incoming goods can be made against the specification against which they were ordered.

100. I have been asked whether I consider that anyone or any company received preferential treatment as a result of their status as a donor of or with a

connection to the Conservative Party in relation to access to the system for procurement and award of contracts. I acknowledge with regard to PPE the fact that suppliers were contacting MPs and senior officials directly and might, as a result, be directed onto the HPL (as the Inquiry refers to it, though the internal phrase was more often "the VIP team") meant that they were given a different route into the process and might be treated more rapidly (though they might not) - and that some such might be donors to or have a connection to the Conservative party (though they might not) - but it was not my experience that anyone or any company received preferential treatment towards getting a contract vis a vis by the procurement teams (I cannot comment on anyone else) as a result of their status as a donor of or connection to the Conservative party, for the reasons that I have explained in detail in my Third Statement, particularly in paragraphs 57 and 58, in reference to the HPL. I am not aware of any evidence of any preferential treatment on such a basis.

101. I have discussed the pressures that the procurers were under in my HPL statement (for example at paragraph 49). The reality is however that ministers and senior officials remained keen to chase the progress of offers and ensure that they were responded to (whether accepted or refused) despite being informed by my team that such chasing was having a negative effect on our ability to work (GRW/82 - INQ000561902; GRW/83 - INQ000561900; GRW/84 - INQ000561899).

102. I am not aware of anyone who gained supply contracts due to political interventions. I am only aware of one contract, the contract with Dyson referred to above, where I was asked to put a contract in place against the commercial guidance. In that case, a compromise was agreed where the contract was awarded contingent on future performance by a due date, which protected value for money and the safety of the prospective patients. I do not believe that was driven by any donation or connection to the Conservative party but due to ministers' desire to expedite deliveries in a critical situation. In the event, that supplier did not meet the required condition by the due date, so the contingent contract fell away with no payments made to them, and the required volume was delivered by others.

103. I have been asked how Dyson came to be involved in the Ventilator Challenge. On 13 March 2020 at 6:36am I sent an email to Patrick Vallance, Steve Oldfield

and Coleen Andrews in which I said "I wonder whether we should quickly get a group of engineers together to make what I realise would in normal circumstance be unacceptable, but right now might save multiple lives". One suggestion I had was that a product development agency in Cambridge could work with engineers "e.g. Dyson." Patrick Vallance noted that if Steve Oldfield felt that the more basic ventilators would be needed then this idea might be worth exploring. I discussed with Steve, (GRW/85 - INQ000534484) and he indicated that he "had an identical discussion with the PM / CDL / SofS / Simon Stevens last night, and they're all keen to get a group of home-grown companies doing their bit to search for a solution" (GRW/86 - INQ000496686). I shortly afterwards forwarded my email to Munira Mirza and Ben Warner in No.10 (GRW/87 - INQ000534483) who responded positively. Later that day Steve Oldfield emailed me to say that "following yesterday's meeting, the PM has apparently sent my mobile number to Lord Bamford (of JCB) and James Dyson (!!)" (GRW/88 - INQ000533270). I had not been involved in any meeting the day before on this and do not know whether the Prime Minister provided Sir James Dyson with Steve Oldfield's number after my message. I was then put in contact with some people at Dyson by Steve Oldfield on 14 March 2020 (GRW/89 - INQ000561911).

104. For the reasons set out in my email on 13 March 2020 it made sense for Dyson to be included in the meeting of 60 manufacturers and suppliers whom the PM met on 16 March 2020. Also included were GTech, who were a competitor to Dyson and who had been raised with me by PA Consulting in the early hours (1:10am) of Saturday 14 March 2020 (GRW/90 - INQ000534485). My team tried to source the contact details of the CEO of GTech that day and I eventually was able to contact him at shortly after midnight on 15 March 2020. We then provided him with the specifications and he agreed to help by mid-morning 15 March 2020 (GRW/91 - INQ000534486).

105. I have been asked whether we considered alternatives to Regulation 32 when developing the Ventilator Challenge. I am experienced in procurement and am well aware of the potential procurement routes under the Regulations, but it was evident to me from a very early stage that no route would offer procurement options which were sufficiently responsive to the urgency of the situation other than Regulation 32(2)(c). Indeed, this was the kind of exceptional life or death situation which Regulation 32(2)(c) was designed for.

(a) The "Innovation Partnership" (IP) is on the face of it attractive but has to allow a minimum of 30 days for requests to participate after a contract notice before we could start reviewing and assessing bids, requires a detailed specification at the outset and would mean that bidders were working at their own risk before contracts were let, unless we had agreed in the award notice to cover all bidders' costs, which would have been a potentially even larger exposure. Although, before the pandemic, I encouraged departments to run trial procurements using the Innovation Partnership procedure, they are, in practice, rare and typically take, in this context, an unacceptably long time to complete.

(b) The more complex procedures, such as Competitive Dialogue (CD) or Competitive Procedure with Negotiation (CPN), also take a long time to complete – typically multiple months, which we did not have, and also require considerable resources on both sides. Standing up the resource for 20 or so parallel CPN processes would have been a considerable challenge for us. Given that we also anticipated that most of the design teams we would be working with would have had limited prior exposure to Government procurement and were anyway quite small companies, we could easily have swamped their management with contract negotiations when we needed them focussed on designing product. In order to start work quickly we would have had to grant work during the negotiation period, which would have meant less control over costs, delivery performance and the down select process than we needed.

106. At the start of the Ventilator Challenge we initially thought that the need was for massive volume of the simplest unit, based on previously published designs. Our initial expectation in pursuit of that (and what happened) was that the teams would cooperate, throwing suggestions to each other in support of the overall objective. That behaviour is not what you get through CD or CPN processes, which are designed to compare mutually unknown competitors against each other, whereas we wanted cooperation; the sharing of good ideas and of ideas that had turned out to be dead ends; and openness on raw material and component sourcing. In the event, the clinical need rapidly moved

to a demand for very sophisticated machines, even if it took longer, and the designs diverged, leading us to consider what mix of what products would be wanted from who. That flexibility would also have been hard to inject into the more complex procedures, even putting the time constraints to one side. At the very end of the project we not only varied the volumes coming from the different suppliers to meet what at that stage was seen by the clinical team as being the most useful mix of products for them, but also upgraded the Penlon product to achieve some functionality not previously required, and were able to get the Penlon product CE marked, which as a new product sourced under emergency rules, had not previously been imagined. Setting this flexibility up under a CD or CPN would have been very laborious.

107. The process we used allowed a rapid 'down select' of the most promising designs, as more fully described in paragraphs 4.42 to 4.54 of the Corporate Statement, under the control on the independent, clinician led, TDA, with tight control of costs; this mirrors much of the IP methodology but was done much faster. As an illustration of the speed of product development and the way the designs increased in sophistication, I refer to a pack of designs from 27 March 2020 and the Ventilator Challenge Scrapbook from the end of July 2020, in particular the images of the Sagentia product on pages 5 and 36 respectively (GRW/92 - INQ000561901 and GRW/93 - INQ000561910).

108. I have also been asked about the decision to give Dyson a contingent order rather than a letter of commitment or intent (I note that it was not only Dyson which received a contingent order: BAE Systems also later received a contingent order dated 2 April 2020 on 3 April 2020). On 25 March 2020 there was discussion with the TDA about which ventilator products should be proceeded with. I was involved in those discussions and at approximately 8:15am I provided Professor Ramani Moonesinghe with a pack from Dyson and stated "Sorry to bother - does anything in this pack from Dyson change your minds? I suspect not, BUT PLEASE confirm and we'll get it shut down" (GRW/94 - INQ000534493). The email thread included text from Lord Agnew and Lord Feldman setting out what the latter believed was Sir James Dyson's position that "his Ventilator is ready to put into production and that it uses far less Oxygen than other designs. We can have 3000 a week in 3 weeks time", and I indicated to Professor Moonesinghe the intense political pressure that Lord Agnew was under to show progress towards delivering ventilators.

Professor Moonesinghe would be aware from press coverage at the time of the political spotlight these deals were under and that we needed the decision making to be watertight. As I said in my email, if the TDA opposed Dyson's participation I would try to get that aspect of the Challenge shut down. Professor Moonesinghe circulated this to her clinical team and said that they would provide a response (GRW/95 - INQ000534498). I forwarded the email to Lord Agnew's private office and asked them not to contact the clinicians directly but that we would contact them with an answer (GRW/96 - INQ000534494). Professor Moonesinghe and I were asked to join a call with CDL later that morning and I wrote to Professor Moonesinghe prior to the call to suggest that she explain to CDL that we had reviewed the data and had decided whatever she (Professor Moonesinghe) thought (GRW/97 - INQ000534497).

109. At that call there was a robust discussion about placing an order with Dyson in advance of clinical approval being secured (GRW/98 - INQ000497223). As set out in the email correspondence above, it was the position of Dyson at that time that the company had prototype ventilators that had been developed and were ready for testing. This was restated in the meeting later that day on 25 March 2020 with the then Chancellor of the Duchy of Lancaster, myself, and Sir James Dyson (GRW/99 - INQ000534490). My view was that this was a misunderstanding of how developed their prototypes were at the time, and how complete they needed to be before the MHRA could assess and potentially approve them, but if it were true it would have put the Dyson product first among all the companies in the Ventilator Challenge and would have made it imperative to provide them with appropriate support such as presenting them at the testing lab first. CDL was insistent that an order be placed. In discussion we agreed that this could be an order contingent on Dyson successfully passing the MHRA's tests and standards by a certain date (GRW/100 - INQ000496699). I explain the effect of that in the paragraph below. As a result of this call the CFO of the Cabinet Office, Richard Hornby, recorded that a purchase order be raised, with me "having been instructed to proceed at pace" by CDL. The specific conditions were to be worked out. We continued to work with the TDA to try to understand the Dyson product specifications and I noted to Professor Moonesinghe some aspects in which it was deficient at that stage, (GRW/101 - INQ000534496) and flagged them also to John Manzoni, suggesting that James Dyson had perhaps not been informed of all of them (GRW/102 - INQ000534492). Sir James Dyson attended a meeting that

afternoon and I emailed Professor Moonesinghe and Duncan MacPherson from the MHRA before it to ensure that they felt equipped to explain to Dyson what they needed (GRW/103 - INQ000534489). A readout of that meeting, with actions corrected by John Manzoni, was circulated afterwards (GRW/104 - INQ000513540). A further meeting took place that evening with CDL and others, and the readout recorded that the contingent order had been placed. The readout stated "GRW said it was likely that the units didn't meet specifications and would fail tests due to not having alarms. The minister acknowledged he was under political pressure to ensure that we have followed up with Dyson" (GRW/105 - INQ000533246). In the event the prototype was not ready to be shipped and tested that evening, contrary to what we had understood from Dyson earlier that day (GRW/106 - INQ000534495). In an email I sent that evening, I attached a photograph of the prototype, which illustrates why I did not think it was ready for MHRA approval testing as yet - it was a 'breadboard' (i.e. just an early stage design with the components linked to each other, but not in the final casing, or assembled in a way that could be used by anyone outside a design team), rather than a finished product in the form that could be tested, and if successful passed to hospitals for in-use testing. I was trying to ensure that the MHRA testing regime was not set aside even in the face of the very clear need for additional ventilators to be made available as fast as possible (GRW/107 - INQ000534491).

110. The terms of the contingent order were that Dyson gain clinical and MHRA approvals and commence production of their model by 13 April 2020 (GRW/108 - INQ000534499). This was an extremely challenging deadline (less than three weeks time) and had Dyson achieved it then they would undoubtedly have been ahead of the game and worthy of a contract and orders for product. At this stage in late March we were very conscious of the limited likelihood that any product would pass testing in the ideally required timescale, and considered that if any product did pass testing they would receive orders. The terms of the contingent order were to my mind in principle and practice not significantly different from the letters of commitment we were providing to other companies (unlike Penlon who received two confirmations of order as they had a more developed design; while theirs was strictly also a new product, it was based on I believe a design using core modules that had been in production in prior years, originally as part of other pre-existing anaesthesia machines:

GRW/109 - INQ000409844).[1] The terms did however enable us to respond to CDL's requirement, as a Secretary of State, that we place an order with Dyson, while making sure that the product went through whatever testing the MHRA required as part of compliance with their emergency regulations. As above, it was my view at the time that the reason for this requirement was a reliance on the communication from Dyson that their product was ready to go, and CDL's belief that if that were true we needed to pick up the offer, given the national crisis. I do not know whether CDL had seen the pictures of the breadboard that the rest of us had. Such pressures are a reality of life in government.

111. As part of the preparation for the Inquiry I have recently seen a readout of texts from the PM from the 25 March 2020 (at 7.53am) indicating that the PM at least believed that the Dyson product was very advanced (GRW/110 - INQ000561918).

112. On 23 April 2020, I co-authored a submission to CDL and Lord Agnew with recommendations on which suppliers to continue with and which to remove from the Ventilator Challenge (GRW/111 - INQ000512994). The recommendations we made followed the TDA's recommendations in its presentation on 22 April 2020 (GRW/112 - INQ000513002) (see the Corporate Statement, paras 4.103 to 4.105). One of the recommendations by the TDA and in the submission to Ministers was to stop the CoVent by Dyson, with 7 other suppliers who were regarded as less clinically viable. The Ministers decided to only remove the 4 least clinically viable suppliers (as assessed by the TDA) and keep supporting the other 4 devices that were much closer to passing testing, for a further week with capped funding. The devices kept in on this basis included the CoVent by Dyson. The reason for this decision was, as explained at para. 4.106 of the Corporate Statement and in the readout from the Ministers' meeting,[2] (GRW/113 - INQ000471010) to allow the supply chain

[1] To correct paragraph 4.116.1 of the Corporate Statement, the second confirmation of order was issued on 29 March 2020, not 7 June 2020. 7 June 2020 was the date of the conclusion, i.e. end, of the contract on the Contract Award Notice. See GRW/202 - [INQ000409844] for the list of Contract Finder Notices where the link to the Contract Award Notice can be found (see sub-paragraph 'Links' under 'More Information').

[2] INQ000471010. I note that there is an error in the readout in listing the least clinically viable devices which were removed. The actual devices which were removed were the EVA by Team Cogent, the Helix by Plexus, the OxVent and the InVicto by JFD. The Gemini, Zephy+ and Florence devices were, contrary to the readout, retained at this point. Our recommendation had been to retain the first two of these devices.

visibility of the Penlon and Smiths devices (i.e. the preferred devices) to improve before a final decision was made to remove these other devices.

113. I was also involved in the discussions with Dyson in relation to their costs of the Ventilator Challenge. Initially, at the end of April 2020 Dyson stated it would not seek its costs. There were then discussions with Dyson about the possibility of it manufacturing its design for markets outside of the UK, for which it would need to pay a licence to the Government for the IP in the design (GRW/114 - INQ000533257). On 13 May 2020, Dyson suggested it may seek its costs. An email was sent on my behalf to Dyson on 14 May 2020 stating that if it wished to do so (suppliers in the Ventilator Challenge were generally paid their reasonable costs) it would need to provide a breakdown on its claimed costs (£20m) for us to review (GRW/115 - INQ000562817). At a later meeting, Sir James informed us that Dyson would not, in the end, be seeking its costs or a licence and would be shutting its ventilator program down. On 15 May 2020, I sent Sir James a letter thanking Dyson for its efforts (GRW/116 - INQ000561903).

## P. DISTRIBUTION OF KEY HEALTHCARE EQUIPMENT AND SUPPLIES

114. As set out at paragraph 4.304 of the Corporate Statement, I was not involved in any process or procedure relating to the distribution of key healthcare equipment and supplies during the pandemic, as the Cabinet Office did not direct distribution activity. The delivery and distribution of PPE was directed by the DHSC with significant assistance from the Armed Forces.

115. Further details about the delivery and distribution of PPE are set out at paragraphs 4.503- 4.512 of the Corporate Statement.

## Q. SUITABILITY AND RESILIENCE OF SUPPLY CHAINS

116. I am not aware of systemic issues in the supply chain before the pandemic, though as in any supply chain there will be occasional issues. The work done by the DHSC commercial team in preparation for Brexit I believe did contribute to the stability of supply experienced.

117. There were multiple supply chains that continued to operate very effectively through the pandemic. The ones that were swamped by demand, PPE as the main example, generated huge problems as discussed extensively in paragraphs 4.289 to 4.295 and 4.374 of the Corporate Statement.

118. I cannot comment in any detail on how private sector supply chains could be improved but believe those supply chains reverted to normal post pandemic. It is an assumption but I doubt whether public sector supply chains are now sufficiently resilient to sustain another pandemic without any disruption. As I refer to above, there are issues with shelf life and having emergency stock and it is expensive to keep plants ready with no immediate requirements. I also refer to paragraph 4.375 of the Corporate Statement in respect of the government's knowledge of supply chains.

119. As stated at paragraph 28, there are methodologies that could be used to improve supply chain resilience, but they come at significant cost. I consider that the shelf life of pandemic stock needs to be dramatically increased if we want that stock to be able to be genuinely effective in future pandemics, otherwise the rotation costs will be huge.

## R. CHANGES TO PROCUREMENT PROCESSES AS A RESULT OF THE PANDEMIC

120. There is much to be proud of in the way procurement teams rose to the challenges of obtaining hugely increased volumes of things they were not used to buying, and buying products that were completely new to us. A lot of this flowed from the integrated structure of the GCF, with departmental teams linked by their common membership of the GCO / GCF and being supported by teams in Cabinet Office that executed functions that are best done once across government. Indeed, the pandemic, as with the collapse of Carillion, demonstrated the value of a function set up on this 'hub and spoke networked model'. Which is not to say everything went as well as it could do / could not be improved on with the learnings of the pandemic. The following paragraphs cover my suggestions.

121. Other ideas for improvement are covered in paragraphs 104 to 117 of my Third Statement.

## S. LESSONS LEARNED (OUTSIDE OF THOSE REFERRED TO ABOVE)

122. Lessons learned during the Covid-19 pandemic would include having a viable safety stock of appropriate PPE before the pandemic of sufficient size, which would have bought us time to get the parallel supply chain up and running. But as discussed above, this comes with very substantial costs. We need to have, ideally, a cross-party and HMT agreement as to what size that stock should be and / or what we are prepared to pay to maintain any sovereign manufacturing capacity. A stock system should be implemented through the NHS and the larger care homes. My suspicion is that pandemic protection will be cheaper to achieve by using stock holdings rather than by trying to build and maintain sufficient sovereign manufacturing capacity, particularly for items with complex raw materials, but that analysis needs to be done properly. It may be that DHSC are already doing this.

123. I cover the following in more detail at paragraphs 108 to 112 of my Third Statement, but one of my biggest regrets, and hence why I repeat my recommendation from previous statements of something we must improve on in this statement, was in respect of prompt publishing of PPE contracts and relevant notices. The failure to publish promptly led to the external narrative that something must be not right about the underlying contracts and a number of press articles alleging bad faith on the part of my colleagues and me. An example of this was when words from an email I had written were taken out of context to suggest that I was asking staff to manipulate the data to conceal the number of suppliers who went through the HPL. The true purpose of the email was that I was asking for a breakdown of how the figures of PPE spending as provided to the NAO was split between HPL spend versus non-HPL spend, in preparation for appearing before a select committee. It seemed important to me to use the breakdown of figures as supplied to the NAO and not the figures for PPE spend at the time of the email (December 2020) because by the time of the latter date there had been significant ongoing purchasing after the HPL had ceased to exist, so that a breakdown of spend at that point might have in fact underestimated the HPL spend as a proportion of overall spend. We have had previous instances where using data taken from different time slices has caused confusion (GRW/117 - INQ000561908) (GRW/118 - INQ000561907) (GRW/119 - INQ000561909). When the contracts and notices were actually

published by DHSC, relatively few generated comment, but by then the damage to public trust was done. The time-consuming task of having to give a justification on a contract-by-contract basis for relying on Regulation 32(2)(c) of the Public Contracts Regulations 2015 will be ameliorated by the introduction of the Procurement Act 2023. The Act allows Ministers to make regulations to allow for the direct award of contracts where necessary to protect life, public order or safety, which maintain transparency provisions, but avoid the need to explain why each and every contract is urgent. This relieves contracting authorities of an additional burden in challenging circumstances but, because of the narrower nature of the grounds and the fact (and the circumstances in which) the regulations will be made, means the justification ought to be apparent. Any transparency notice in respect of such a direct award is also required to expressly refer to the regulations.

124. I would advise promulgating a 'commonly agreed' set of demand forecasts more frequently and more widely, so that (as was done with the ventilators when it was detected that demand was reducing) intelligent actions can be taken to trim supply and save resources. Given that in times of a pandemic, these forecasts are extremely politically sensitive, the list of who has those latest forecasts should at least be known so that those people can be asked for input.

125. I would advise ensuring that properly empowered procurement professionals, familiar with the rules that have to be adhered to, are embedded in all the teams that are looking to conclude contracts, sufficiently early to be able to influence outcomes. In times of huge surge in resourcing, I would advise trying to ensure that external staff brought in are <u>always</u> under the direction of full time, trained public servants. To explain further:

    (a) They (experienced public servants) were only put into Test and Trace, and then with insufficient power to enforce best practice, after many of the lab contracts had been agreed. Granted, this was also a sellers' market, so we were never going to get all we wanted as regards terms and conditions, but that means that there was even more reason to bring in enough of the people most qualified to help.

(b) The order for antivirals was a similar case. As above, the antivirals team in DHSC requested, in the strongest terms, that immediate approval be given for the purchase of £11bn of antivirals, without, as I recall, any in-house DHSC commercial person being involved. When I tracked down the SRO, she was also surprised at the order size, thinking that the team had been going to ask for £1bn. The DHSC COO had also not been kept in the loop. As a result of 'not having the right people on the team early enough' we ended up with a single set of orders for 2 years' worth of product, albeit delivered as the manufacturer could make them, but unlinked to any usage data. For whatever clinical reason, I do not believe we ever used more than 5% of the volume bought. This is not to say that with proper in-house commercial staff we would have had no excess stock, but hopefully the risks would have been flagged earlier and comfort given that there was no other, less costly, way of buying these products.

126. I would advise ensuring that IT systems are scaleable, and sufficiently modern, to allow additional users to be quickly set up on them. Part of the problem with collating the PPE contract documentation (and why we had to develop the Mendix database in the Cabinet Office which, while it did not give all the functionality that one would ideally have wanted, did enable the tracking of PPE leads) was that everyone used their 'home' department's systems because the NHS Supply Chain IT infrastructure was at breaking point before the pandemic and could not handle the extra users that we needed. There were similar issues with access to the DHSC or SCCL systems. I had conversations at the time about getting access to the DHSC/SCCL systems but such access was not obtained. There was therefore significant work done by people in my team and GCF to try to resolve data issues, and ultimately working with the external company Mendix to create as good a system as they could in the time available (GRW/120 - INQ000561898; GRW/121 - INQ000561904; GRW/122 - INQ000561906; GRW/123 - INQ000561905). Action is already underway to complete the upgrade of the SCCL systems, and warehousing systems, and to implement pan civil service 'service centre clusters', using standardised and more modern systems, but the general point is still valid.

127. The accidental oversight in the Cabinet Office at the end of the Ventilator Challenge, where some contract notices were not published, underlines the risks that arise when departments that do not normally act as operational departments, (Cabinet Office and DHSC in this case) have suddenly to do operational tasks that they are not used to doing and whose processes and IT are not set up to do at volume. The new requirements on notices will help avoid this situation as the lack of a subsequent notice in an otherwise full series will be easily detectable.

128. The government should be prepared to cancel orders that are clearly surplus to requirements, even if it means paying a penalty or 'paying for nothing'. It is better to suffer a small loss than pay full price for deliveries that then have to be scrapped.

129. A large part of the argument for central testing stations was to ensure consistency of test results. This centralisation (in the Lighthouse Laboratories and then the Megalab, though it came on stream too late to be truly useful) did however inject delays in getting test results, because tests had to travel from wherever they were taken to the central lab, wasting around half a day to a day. A design and prototype were generated for 'Lamp in a box' automated units that were much more labour efficient, and promised to give very consistent results and which could be installed in multiple local sites, thus eliminating most of the travel delay of the sample. Additionally, being dispersed, the risk of a large, centralised lab going offline because of a covid outbreak at such a lab is eliminated. Several prototypes were made – these designs (of the robotic system that served the LAMP units and / or the already in service ECR testing units from e.g. Thermofisher) should be preserved and prepared for roll out in the event of another pandemic.

130. More widely, if something needs scaling up rapidly, the services of people who are used to doing that from within manufacturers who are used to re-engineering designs and processes to do just that should be engaged. It took too long for Test and Trace to recognise that meaningful amounts of the labs capacity was being wasted due to lack of samples, or that lack of control in the buying of test tubes (and hence buying many different variants) was constraining the capacity of the robots feeding the test machines, further wasting vital testing capacity. None of the brought in consultants (Deloitte's etc)

had the knowledge to spot this issue. This may sound like an extremely detailed point, but, when large amounts of UK wide policy and the treatment of potentially very ill patients, were hanging on knowing what the test results were, and on growing testing capacity, any hiccup in their delivery was massively important.

131. I would advise ensuring that fast growing operations have suitably experienced financial controllers in place, or transferred in from other departments, who are remaining cost conscious. That Test and Trace could be so inaccurate in their spend forecasts I am afraid indicates that their underlying costs were not well controlled, as if they had been, then the overall monthly and YTD totals would have been vastly more accurate.

132. Test and Trace suffered from changes in senior personnel. For some reason a number of very senior executives, all excellent in their own fields, were brought in as CEO / COO, but only ever for 3-month contracts. Not coming from fields related to the mass scale up of complex medical tests, not knowing the organisation they were being brought in to manage, and not having clear delegations or accountabilities, all limited their effectiveness. (This is addressed in the 'Boardman 3 report'). By the time they had started to work out how everything worked, they were rotated out again. It would have been better to have had people with more relevant backgrounds (even if less luminous) there for longer.

133. The Procurement Act 2023 marks a major step forwards in simplifying the way in which public procurement must be carried out, but enacting it alone will not embed the benefit. A comprehensive training program has been rolled out by the GCF training team in the Cabinet Office, but it only covers officials. I would recommend that new Ministers, and ideally some staff in their offices, are trained on:

(a) How the Act works; and

(b) How they should interact with officials and potential suppliers. The 'Principles for Ministerial involvement in commercial activity and the contracting process' of July 2022 or subsequent updates should be issued to all new ministers; and

134. On or shortly after appointment they should attend a briefing on how to get the best out of both officials and suppliers in pursuit of their policy aims. A pack of training material, 'Improving Policy Delivery through 3rd Parties', was valued by the ministers who attended previous centrally run sessions (GRW/124 - INQ000534541).

A combination of the above will help enable ministers and officials to navigate the procurement issues in a future pandemic.

135. Finally, I have some comments and recommendations on how the structure of procurement in the NHS and DHSC has been and could be altered to enable a future pandemic to be more easily handled. Before the pandemic, there were two aspects of the commercial structure which negatively affected the way the overall commercial response could operate. First, SSCL (or as now named NHS Supply Chain) was seen as an arms-length body of DHSC, not as part of the NHS. This had the following effects:

(a) At the time, central government arms-length bodies were not seen as being by default part of the GCF. So their senior staff, depending on circumstances, might or might not have been through the GCF ADC, the key mechanism for ensuring that senior staff had the relevant competencies. As it happens, a number, three or so, of the SSCL staff were employed by the GCO and seconded in to SCCL, as were senior commercial staff in DHSC. However, that was more by chance than methodical. As a result, the SSCL team and how it operated was a matter purely for its then board.

(b) Their customers, the NHS trusts, regarded them with some suspicion. SSCL's market share with trusts of the things it could provide was, to the best of my recollection, around 50% initially with a target of 75%. At that time, it was expected that NHS trusts would be able to negotiate with vendors independently of SSCL or the NHS centre.

136. Second, there was no NHSE/I level senior commercial director overseeing the whole of the procurement budget of the NHS. There was a commercial team in

NHSE/I, however, they were mainly focused on buying the items that NHSE/I needed for its own operations, rather than on the whole of the c.£30bn spent externally from within the wider NHS. I had attempted, before the pandemic, to persuade NHS chairs / its CEO to recruit someone suitable but failed to do so. The recruitment campaign in 2019 came closest to placing someone from the outside but that too did not complete. Consequently there was no one in that post and no established job title such as 'NHS Commercial Director' or structure beneath it in the period running up to when the pandemic hit.

137. When the pandemic hit, Emily Lawson was appointed as NHS CCO. However, SSCL still reported into DHSC and the NHS trusts continued to be able to buy on their own account. In an already overheated market like PPE, this effectively meant they were at least risking competing with each other and the centre for scarce commodities.

138. Coming out of the pandemic, several lessons have been learned.

(a) DHSC and the NHS agreed that it was more logical if SSCL was transferred to the NHS. This allows SSCL to interact more directly with its customer trusts. This happened in October 2021. Since then, SSCL has indeed grown closer links with the NHS trusts. It has also started to roll out a new warehouse management system and has pulled in-house a number of the purchasing category towers that were previously outsourced. This builds internal knowledge in those markets. How much they should store in that network of new sites against a future pandemic is a political and cost question, but their system is now massively better able to react than before.

(b) The NHS CCO post has been retained and, with Emily Lawson moving to No.10, the GCF supported the NHS board in running an open and fair competition for an NHS CCO. This was won by Jacqui Rock, who was a GCO employee at the time, having been until then the CCO for Test and Trace and previously the Commercial Director for DIO, part of the MOD. Although working for the NHS not the GCO in that role, the background and contacts built up have really helped her to be effective in the NHS and to roll out a number of initiatives right across the NHS.

(c) In particular, the almost 100% adoption of the same procurement (as distinct from a stock) system - Atamis - has meant for the first time that colleagues can see who is buying how much of what and from whom and indeed what they are paying for it. This is a huge step forward towards aggregating demand and driving value for money. Additionally, the NHS and GCF have agreed, as have local councils, to adopt the same system of commercial operating standards, against which all units (currently some 200) can now benchmark themselves and learn the best practice adopted by peer organisations.

(d) But the right structure even with the right systems will not work unless it is properly staffed. My Third Statement discussed at para 117 the disparity between how much the private sector spends on its procurement teams and that in the public sector. The effect of having too few people (or underqualified ones) is often that contracts that should be let regionally or by product are aggregated up to be national ones, narrowing the number of companies that can bid, or leading to incumbents winning again, in order to save procurement staff time. Given the much larger costs of what is procured, this is very counterproductive. The relevant example is SSCL, which before the pandemic used external companies to operate 'category towers', where each company assumed responsibility for procuring and supplying the products within their contracted category. This does indeed require fewer internal people but means that knowledge about those market categories is left with the external supplier. When issues arise, having a third party involved also usually impedes speed of reaction. SSCL is now allowed more people, and is going through a process of insourcing a number of those towers.

(e) The GCF has developed a workforce planning tool, Blueprints, which is used to derive, for a given procurement load and scope, what an appropriate headcount and organisation structure would be, benchmarked to peers and the private sector. I would recommend that generating and then adhering to agreed Blueprints is made mandatory for entities with a large procurement spend.

139. As regards further recommendations:

(a) Ms Rock has recently announced she will be leaving the NHS in December for a role in Saudi Arabia. My recommendation would be that her role is recruited for and filled as soon as possible with someone who, although employed by the NHS on NHS terms, passes the most stringent of the GCO assessment centre tests. Whoever wins it should report functionally, not directly, into the GCCO role in order to better enable them to leverage off what has already been developed in the GCF, for eg the ADC and training resources, and for the rest of public sector procurement to learn from whatever the NHS commercial team develops.

(b) Currently the NHS does not have a mature mechanism for managing, across the NHS, their relationships with their key vendors. The rest of government uses a network of Crown Representatives and supplier partnering managers to drive better delivery from their larger vendors. That mechanism should be rolled out, initially with the top vendors but over time expanding the list. Had something similar been in place during the pandemic, for example with the major test equipment companies, we might have been able to scale up faster.

(c) Over time, the NHS should determine which categories of goods will be negotiated centrally, which at regional level, and which at NHS trust level. This would make their market much easier to manage and to ensure that the same price is being paid by each NHS trust for the same item, which is far from the case today.

(d) As discussed in my Third Statement, should ad hoc teams be set up in DHSC or NHS in future pandemics, e.g. the antivirals team, they must be set up with accredited commercial resources who should report, respectively, into the DHSC or NHS commercial directors. They can then operate within an established structure.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

**Signed:**

**Personal Data**

**Dated: 23 January 2025**