Witness name: Gareth Rhys Williams

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UK COVID-19 INQUIRY

CORPORATE WITNESS STATEMENT OF GARETH RHYS WILLIAMS

CONTENTS

I, Gareth Rhys Williams, will say as follows:

1. SECTION A: INTRODUCTION AND EXECUTIVE SUMMARY

Introduction to the Author

1.1 I am 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. 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.[1]

1.2 This corporate witness statement is produced to address queries that have been raised in a Request for Evidence pursuant to Rule 9 of the Inquiry Rules 2006 and sent to the Cabinet Office on 19 December 2023 (the 'Rule 9'). The statement also addresses a range of more detailed follow up queries from the Inquiry and some from an additional Rule 9 request sent to the Cabinet Office on 31 May 2024. The statement has been prepared with the assistance of Counsel and lawyers at the Government Legal Department. My statement draws in part on my direct experience, as well as on papers and accounts provided by others who worked in the Cabinet Office including No.10 at the time.

1.3 I have also provided a corporate witness statement to Module 1 of the Inquiry, dated 28 April 2023.[2]

Introduction to the role of the Cabinet Office including No.10

1.4 As the Inquiry has heard in earlier modules, the Cabinet Office including No.10 coordinates the effective functioning of government. This includes advising on overall strategy, facilitating collective agreement through the ministerial committee structure, determining the structures for the making of decisions and assurance of progress, providing challenge and acting as a point for escalation where needed. As the Cabinet Manual sets out, "Cabinet is the ultimate decision-making body of government…

[1] My biography is available at GRW/1 - [INQ000471037]
[2] GRW/2 - [INQ000182611]

Cabinet is chaired by the Prime Minister, who also determines its membership… Cabinet committees help to ensure that government business is processed more effectively by relieving pressure on Cabinet. Collective agreement can be sought at a Cabinet or Cabinet committee meeting or through ministerial correspondence".[3] The Cabinet Office including No.10 also plays a key role in providing advice to the Prime Minister and other ministers about the issues and priorities on which they should focus their time and influence, for example to strengthen important stakeholder relationships, unblock challenges or expedite delivery.

1.5 As the Cabinet Office Module 2 corporate statement explains, given the breadth of the role of the Cabinet Office including No.10 in the Government response to COVID-19, the Prime Minister also needed to have a wide set of meetings in addition to the collective agreement structures described above. The format, frequency of and attendance at these meetings were tailored to the issues at hand and the nature of the discussion taking place. The aim of these meetings varied from one to another but overall they sought to: provide lead ministers with data, analysis and expert advice; make or prepare for decisions; coordinate other government departments; and, consider and sometimes make decisions on specific policy and operational issues such as Personal Protective Equipment (PPE) and testing, with the attendance tailored to those issues. These meetings were sometimes referred to as 'deep dives' where an individual or several topics were considered in detail.

1.6 The Prime Minister was personally involved in setting some strategic targets for some key areas of procurement - for example in relation to the Ventilator Challenge and testing[4] (targets for PPE were set by DHSC)[5]. The Cabinet Office including No.10 was also keen to ensure that departments had the support they needed to procure other necessary goods and services, such as PPE and testing, and to provide assurance to the Prime Minister that this was the case, through for example stocktakes or deep dives with relevant ministers, officials and advisers.

1.7 The Cabinet Office Module 2 corporate statement also set out how the formal structure of Cabinet government operated. From the beginning of the Module 5 relevant period (1 January 2020 - 28 June 2022) to 15 March 2020, those decisions in respect of COVID-19 which required collective agreement were taken through the Cabinet Office Briefing Room ("COBR") mechanism and the Cabinet also considered the

[3] GRW/3 - [INQ000086861]
[4] See paras 4.68 onwards to 4.89 and 4.258
[5] See para 4.314

Government's response[6]. From 16 March to 27 May 2020, four Ministerial Implementation Groups (MIGs) led the key lines of operation and reported into a daily 9.15am strategy meeting of key ministers, officials and advisers chaired by the Prime Minister and attended by the chairs of each of the MIGs. The MIGs were each chaired by a different Cabinet minister, and had the status of Cabinet committees and the ability to take collective decisions. They were: the Health Ministerial Implementation Group (HMIG), chaired by the Health Secretary; the General Public Services Ministerial Implementation Group (GPSMIG), chaired by the Chancellor of the Duchy of Lancaster; the Economic and Business Response Ministerial Implementation Group (EBRMIG), chaired by the Chancellor; and, the International Ministerial Implementation Group (IMIG), chaired by the Foreign Secretary.

1.8 With effect from 28 May 2020, the MIGs were stood down and replaced by the COVID Strategy Committee (COVID-S)[7] and the COVID Operations Committee (COVID-O)[8]. COVID-S and COVID-O were supported by the COVID Taskforce, which was based in the Cabinet Office. The Taskforce was the unit at the centre of government which joined together strategy, analysis and coordination with departments across Whitehall to drive delivery across the full range of policy issues. On 5 June 2020, Simon Case, then Permanent Secretary in No.10, wrote to Permanent Secretaries announcing the Taskforce. This body initially reported to Simon Case as the Permanent Secretary in No.10 responsible for responding to COVID-19 and coalesced over the summer of 2020. Simon Ridley and Kate Josephs led the Taskforce until James Bowler was appointed Second Permanent Secretary in the Cabinet Office with responsibility for leading the Taskforce from October 2020. The Cabinet Office has provided in Module 2 factual narratives which summarise chronologically the meetings of Cabinet and its committees and which attach the key documents from those meetings. We stand ready to assist the Inquiry to review this information from the perspective of Module 5.

1.9 The Cabinet Office has a wider role at the centre of government, coordinating delivery and driving change through the functional model. The Cabinet Office houses a number of functions including: commercial, communications, digital, human resources, project delivery, property and security. This functional model promotes improved decision making, cross-departmental working, organisational capability, efficiency, resilience and control.

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[6] Ministers continued to meet in these structures for the remainder of the relevant period.
[7] The Cabinet Office has provided the Inquiry with a full chronology of COVID-S meetings - GRW/4 - **[INQ000496745]**
[8] The Cabinet Office has provided the Inquiry with a full chronology of COVID-O meetings - GRW/5 - [INQ000177566]

A brief explanation of how the Government Commercial Function relates to the Cabinet Office

1.10 I am a Cabinet Office official, and as GCCO I lead the Government Commercial Function (GCF), which is a cross-government network of staff based in all departments, who procure or support the procurement of goods and services for the public sector, among other tasks.

1.11 While there have always been commercial teams in government departments, procuring the contracts needed to deliver each department's agenda, the GCF was brought into being as a pan-government network in 2014.

1.12 During the pandemic the GCF provided departments across government with personnel and advised on ways of working to enable better procurement, and to help them achieve their goals.

1.13 The Cabinet Office employs the senior cadre of the GCF (c.1500 staff) who are on different terms and conditions to other civil servants (as explained below in paragraph 2.16) through the Government Commercial Organisation (GCO). In practice, GCO employees work in both the Cabinet Office and other government departments (OGDs) into which they are deployed. All GCO employees are part of the GCF.

1.14 The Cabinet Office also houses the Crown Commercial Service (CCS). CCS is a trading fund and an Executive Agency of the Cabinet Office. CCS, which is a major element of the GCF, puts in place overarching procurement agreements (frameworks and dynamic purchasing systems - see paragraphs 3.11-3.13) for common goods and services on behalf of the UK public sector. Its senior commercial management are employed by the GCO. The role of Crown Commercial Service during the pandemic has been described by Simon Tse, Chief Executive.[9]

1.15 The majority of commercial staff are based in departments, or their arms' length bodies (ALBs), executing contracts for items or services that are bespoke to that department - for example, the Ministry of Defence (MoD) buying military equipment, or the Ministry of Justice (MOJ) buying prisons. This is done either by letting individual contracts for an item or service, or by executing a 'call off' contract from a previously established framework or dynamic purchasing system covering items that are bought frequently. Increasingly, for commonly purchased goods and services, those frameworks used by central government (and other contracting authorities) are put in place by the CCS.

[9] GRW/6 - [INQ000106033]

The focus of this statement

1.16 While I am providing here a statement solely on behalf of the Cabinet Office including No.10, given the GCF is a cross-government network of staff that I lead as the GCCO, and given that at senior levels GCF staff are formally employed by the Cabinet Office (even when they are in practice working in another government department), I seek to provide some account of the procurement work that was both directly led by the Cabinet Office and that was undertaken by Cabinet Office officials[10] deployed into DHSC and NHS Test and Trace during the pandemic. This is in order to provide the Inquiry with as full an understanding as possible of procurement during the pandemic. I understand the Inquiry will also receive detailed accounts of this procurement activity from OGDs as relevant.

1.17 To illustrate the above, the Cabinet Office *directly* led a critical project to manufacture ventilators in the UK and awarded contracts for this project as a 'contracting authority' under the Public Contracts Regulations 2015 (2015 Regulations)[11]. In addition, Cabinet Office officials belonging to the GCF *assisted* OGDs on other critical purchasing tasks. These included the procurement of medical grade PPE and antigen testing capacity. In these latter two cases, contracts were awarded by the relevant OGD (i.e. DHSC), with GCF staff from the Cabinet Office providing assistance in the procurement process leading to the awards. These departments remained responsible for the award and management of contracts. Procurement activity across ventilators, PPE and testing is discussed in Section D of this statement.

1.18 Significant effort was also put into mask manufacturing (for use in settings other than healthcare settings); the death management process; laptops for schools; food packages; and other areas of Test and Trace. I have not been asked about these by the Inquiry at this stage. The variety and breadth of these projects show, however, that the GCF was able to work effectively and deliver in support of multiple parallel departmental requests. These and other commercial projects required cross-governmental working on a wide scale.

1.19 The MoD described the COVID-19 response as its "biggest ever homeland military operation in peacetime".[12] Similar words would describe the Government's commercial response to COVID-19, in which the GCF played a central role. While there can be no

[10] Where this statement refers to 'Cabinet Office officials' I am referring to civil servants employed by and based in the Cabinet Office.
[11] GRW/7 - [INQ000372757]
[12] GRW/8 - [INQ000471056]

comparison with the actions of frontline health and social care workers, who faced many months of stressful and dangerous work, behind the scenes, commercial professionals across Government came together to buy essential equipment for them, and in addition help set up a national testing network from scratch. This work was carried out at great pace, working in improvised and usually virtual teams and in unprecedented market conditions. Working in good faith, they made mistakes, which we are clear about in this statement, wanting future teams of officials to learn from them. They also achieved a lot, and thus we can also learn from their significant achievements in the event of another pandemic or similar emergency.

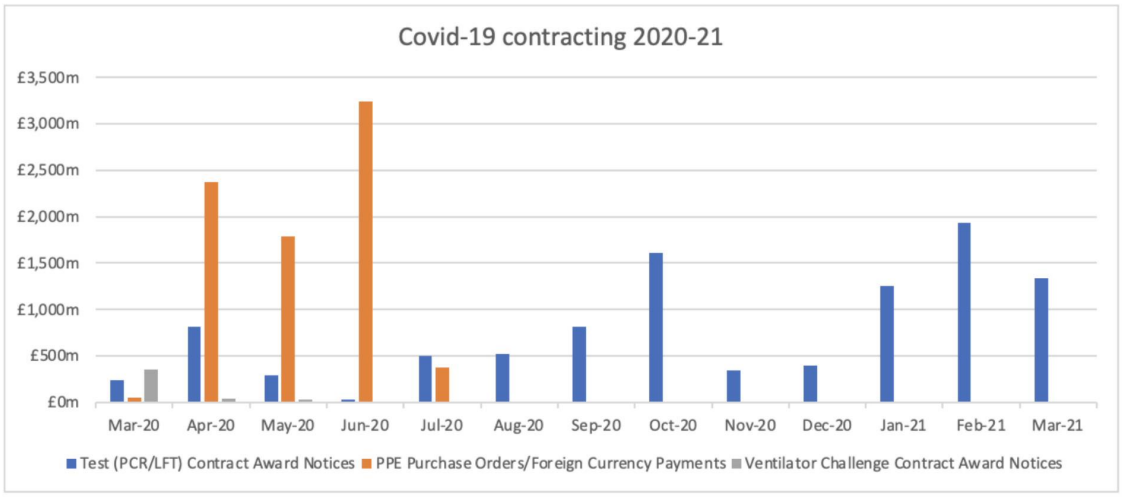
1.20 I am aware that the procurement process has been subjected (rightly) to much scrutiny, both during and since the pandemic. It has been asserted that initial stocks were insufficient, or alternatively that too much was bought for too much money; that the procurement process was not streamlined or quick enough, or alternatively that it was too lax and vulnerable to fraud or unequal treatment. While some of these issues must be answered by other departments (for example DHSC, UKHSA, FCDO and DBT), I take all such criticisms very seriously. Of course it is for the Inquiry to reach its own conclusions on these issues, on the basis of the extensive evidence that it will have. I make the following general points at the beginning of this statement to illustrate the background:

(i) The scale of the challenge

1.21 Throughout the response to the pandemic, hundreds of contracts were entered into in circumstances of extreme urgency and very overheated "sellers' market" conditions. Under these contracts, goods and services were acquired that allowed the NHS to keep functioning, tracked the progress of the disease, provided vaccinations for millions of citizens and supported those most impacted by the pandemic.

1.22 The following chart shows the scale and compressed timing of the contracting in three of the vital areas addressed above and in this statement (the procurement of vaccines is not included as it is covered in Module 4 of the Inquiry, and the figures given are indicative of the scale of the procurements undertaken involving Cabinet Office staff). For comparison, the amount spent on PPE by NHS Supply Chain in 2019 was approximately £5m every month (see para 4.288).[13]

[13] GRW/9 - [INQ000496751]



1.23 Forecasting demand for these goods and services (a responsibility of DHSC / NHS England & Improvement ("NHS E&I")) was an extraordinarily difficult job, especially at the beginning of the pandemic when data was scarce and when significant procurement activity was undertaken. The forecasts of demand were based on the SAGE Reasonable Worst Case Scenario, which at the end of February 2020 estimated 520,000 deaths[14]. In addition there was a lag between buying decisions being taken and product availability. Buyers were 'buying forward' against estimates of future demand at the time when the product would be delivered, and these estimates were based on necessarily uncertain forecasts. Guidance stated that contracts should be short-term (as market conditions might change) and efforts were made in some cases, to negotiate more flexible terms such as gainshare arrangements, but in a seller's market suppliers were aware that they could in many cases readily sell their goods to other buyers, and in the early stages, frequently name their price. In the event, as data given to the NAO by DHSC shows, between February and July 2020, DHSC procured (via SCCL and the newly established Parallel Supply Chain, as described below in paragraph 1.69) 32.0 billion items of PPE at a cost of £12.5 billion. This compares with 1.3 billion items bought by SCCL at a cost of £28.9 million over the same months in 2019 when SCCL supplied about half of the NHS. While DHSC will have the exact comparator, and although the product mix changed, this appears to be a 12 fold uplift in volume and more than 200 fold uplift in expenditure.

(ii) Buying strategies and market conditions

1.24 The GCF teams then sought to acquire these goods and services (directly or by assisting OGDs) in market conditions that were unique and highly challenging.

[14] GRW/10 - [INQ000182331]

Traditional sources had no stock. In PPE in particular, third party speculators entered the market, buyers for other national healthcare systems gazumped pre-existing orders, and just-in-time contracts with overseas suppliers put in place for an emergency situation were not honoured.

1.25 Pre-pandemic buying strategies were not effective in these new conditions. As an example, prior to the pandemic PPE was treated as a relatively straightforward commodity, bought through specialist UK wholesalers. Pre-pandemic, the supply chain was optimised for cost, with as little stock held as possible, as frequent and reliable deliveries could quickly replenish stocks at the point of use. In the pandemic the wholesalers quickly ran out of stock and could not readily obtain more. As a result, using research commissioned by the Department for International Trade (DIT), the GCF teams quickly acquired an understanding of where the PPE and the underlying components and raw materials were manufactured. This analysis (by external consultants at Ernst & Young) fed into the Sourcing Strategy produced by the GCF for the procurement of PPE and was used to guide the organisational design of the procurement operation and tactical/strategic decisions (see paragraph 4.340).

(iii) Value for money and taking decisions in an emergency situation

1.26 In order to buy healthcare equipment during the pandemic, we were forced to act in disturbed markets where the supplier had all the power. We maximised our attractiveness as a buyer, for example by aggregating and centralising the purchasing of key health equipment such as PPE and ventilators, so as to increase the order quantities available to potential suppliers. There is no doubt that in the spring of 2020, prices, particularly for PPE, were greatly inflated over those available in 2019, driven by supply constriction and the simultaneous huge increases in international demand. The prices paid for the goods were negotiated, but there was not time to run 'formal' competitions, as the goods would have been long gone within the minimum 25 days that this would have taken. Prices did vary considerably - goods on short delivery were worth more than those that could not be delivered until much later. Value for money was always on the mind of the Accounting Officers, who were taking the ultimate buying decisions, but they had to balance the cost of buying goods with the much higher costs and impacts of *not* having the necessary supplies in place. This included relaxing certain requirements for evidence of financial standing from those that would usually be required by the UK Government outside of a pandemic situation in order to secure contracts with new suppliers. To assist in decisions on whether to proceed with

suppliers we compared the offered prices on prospective orders with recent market prices for similar products available at that time (see paragraph 4.351 below).

1.27 In the context of the above pressures, and the fact that to help manage the workload commercial staff had been surged into DHSC without prior experience of medical PPE purchasing to support the experienced staff in DHSC, the NHS, there were goods purchased which were identified after delivery as being non-compliant with the specifications. For example the FFP2 respirators purchased from Ayanda complied with BS EN 149:2001+A1:2009, however they did not comply with the additional requirement to have head straps, rather than earloops, which was not fully appreciated as a requirement of the specification at the time of ordering (see paragraph 4.496 in Section D).

1.28 Other items (such as flat-pack aprons) were purchased on the basis that they would be used in the crisis situation (where the alternative might be no aprons at all) but were not used when the crisis lessened (when the use of aprons was much lower, and roll pack aprons were preferred by the NHS). This was compounded by the restricted ability to inspect goods before arrival in the UK. This topic is discussed in Section D below. It should be noted that such issues are inherent to any procurement process, let alone those conducted in such an extreme environment. In practice the quantity of goods that did not meet quality standards was lower than the allowance made in initial estimates.[15]

(iv) The impact of the call to arms and the entry of new suppliers into the market

1.29 The above pressures on existing stocks and suppliers led to significant efforts by No.10 and others to attract potential new suppliers of ventilators, testing supplies and PPE into the market, such as by way of a series of "calls to arms". Many new suppliers responding to the pandemic emergency worked extremely hard to create successful products in a short timeframe, and this led to the success of the Ventilator Challenge. The very large number of offers for PPE, however, led to extreme stress on the procurement system as approximately 25,000 offers were received from 15,000 suppliers in a period of only around 15 weeks. The webform (as described in paragraph 4.482 below) was opened on 30 March 2020 and within 7 days the Parallel Supply Chain was working on almost 3,000 offers. Even during June 2020, during peak periods over 300 new offers were being received every 24 hours. These offers were analysed and many were found (though the offer may have been

[15] GRW/11 - [INQ000475559]

well-intentioned) not to be viable or suitable. Further description can be found in Section D from Paragraphs 4.371 onwards.

1.30 Some offers, though they came from (on the face of it) unusual sources, did have links to manufacturers that could properly be and were explored. While we subsequently complied with statutory requirements to keep written reports of procurements and publish contract award notices (as set out in regulations 84 and 50 of the 2015 Regulations - although we acknowledge that many of the notices were published later than the required date), in retrospect, we should have been clearer (in other, less formal communications) about explaining why some of these vendors were used. They included for example:

1.30.1 A contract was entered with Crisp Websites Limited (t/a Pestfix), a pest control company, because its supply chain included manufacturers in China who supplied them with PPE suitable for e.g. fumigation operatives, but who could also make medical grade PPE.

1.30.2 A contract was entered with Clandeboye Agencies Limited, a confectionery company, because it was already a UK distributor for Medtecs (Cambodia) Corp Limited, a Taiwanese manufacturer and distributor of PPE with factories in Cambodia, China and the Philippines; and Clandeboye had already had an offer of gowns accepted by NHS Wales.

1.30.3 A contract was entered with Ayanda Capital Limited, a company that deals in currency trading, offshore property, private equity and trade financing because the original proposed contracting party, Prospermill, did not have international banking facilities. The offer came from Andrew Mills, (a former advisor to the Board of Trade), who had obtained exclusive access to the full manufacturing output of a factory in China operated by Zhende Medical Company Limited, a Chinese mask manufacturer. Mr Mills was also an advisor to Ayanda at the same time and when Prospermill's balance sheet was deemed insufficient for this order, he suggested running it through Ayanda as it was more substantial. This was a unique opportunity to acquire very high volumes of PPE.

1.31 A further side effect of the cross-government urgency to find viable suppliers for PPE was that GCF procurers were repeatedly chased for progress by those who had introduced possible suppliers into the system. This was a drain on the procurers' already strained resources and in order to handle such chasers a small team was established to handle them and provide feedback. This became known as the "High

Priority Lane" (HPL). The principal purpose of the HPL was to reduce the pressures being caused to the system by the referrers of potential suppliers, though the side-effect of having a smaller offer pool than the broader team meant that often offers were in practice reviewed more swiftly. Further, many of the offers that had been escalated or directed by officials through the HPL were by their nature high value, serious offers, because they were directed to the HPL by officials or ministers who may already have believed them worth pursuing. The HPL team was tasked with an initial review of these offers[16] and deciding whether to progress the proposal for a technical review which would check that the product was likely to be compliant with the published specification. This technical review activity and all subsequent process steps including Accounting Officer approval and the signing of the contract were independent of the HPL team and carried out in the same way for HPL offers as for non-HPL offers (see paragraphs 4.389 onwards).

1.32 In a legal challenge to the Secretary of State for Health and Social Care's awarding of a number of contracts which had been introduced via the HPL,[17] it was found that the operation of the HPL breached the principle of equal treatment because the resourcing of the HPL meant that offers might be responded to more quickly, though it was also found that each of the offers that had been challenged (by Ayanda and PestFix) "justified priority treatment on its merits" and even if they had not been processed by the HPL "it is very likely that the offers would have resulted in the award of the [supplier's] contracts".

(v) Regulatory backdrop

1.33 While being conducted at pace to meet the urgent need, all procurement had to comply with the 2015 Regulations, including the principle of equal treatment, and policy requirements to demonstrate value for money. Processes had to strike a balance between speed and rigour. Other than where there was an existing framework, direct awards (under regulation 32(2)(c) of the 2015 Regulations) were the only practical way of rapidly obtaining scarce goods in a sellers' market. It was considered that the existing provisions in the 2015 Regulations in respect of urgent requirements gave sufficient flexibility for the circumstances of pandemic procurement, and government guidance focused on complying with the Regulations through reliance on those flexibilities, and commercial policy.

[16] GRW/12 - [INQ000480604], GRW/13 - [INQ000496700]
[17] GRW/14 - [INQ000477966]

1.34 The quickest competitive procurement processes in the 2015 Regulations, even when using accelerated timescales allowed for in a state of urgency, still require a minimum of 15 days between advertisement and award, plus a 10 day mandatory standstill period prior to entering into a contract. In practice, additional time is also needed for the preparation of the procurement documents and the evaluation of bids. During the urgent procurement of the pandemic in 2020, those time periods would have been too long. The PPE required by the NHS would have gone to other buyers, or the factory space required for e.g. PPE or Lateral Flow Test (LFT) production would have been booked out for other contracts for other countries, and the Ventilator Challenge would not have been able to commence in the form and with the speed that it did.

1.35 The Cabinet Office was responsible for publishing the contract award notices for the Ventilator Challenge, and I regret the delay in publishing the notices, as discussed in paragraphs 3.29 and 4.120. DHSC was responsible for publishing the contract award notices for PPE and Test and Trace, which were also subject to delays. These delays allowed a narrative to build at the time about the propriety of the process where in reality, the huge increase of volumes and the additional reporting detail required (rightly) when using direct awards, swamped the ability and capacity of the publishing teams to publish within normal timescales. Publishing contract details in a more timely manner would have helped maintain public trust in the procurement system. In future, it would be sensible, if possible, to dedicate additional resources (procurement specialists with legal support) to this task. While not part of the initial urgent procurement tasks, it is plainly important.

1.36 Changes have also been made by the Procurement Act 2023 to provide for a new power for Ministers to make provision in Regulations allowing the direct award of contracts when necessary to protect human, animal or plant life or health or public order or safety so that contracting authorities can procure at pace in situations such as a pandemic. There will still be a requirement to publish information about the contract but the obligation will be less onerous and easier to do rapidly under these provisions because there will no longer be a need for authorities to individually justify their decision to directly award relevant contracts. No consideration was given during the pandemic to the possibility of relaxing the legislative and policy requirements and timelines for the publication of award notices. It was not initially recognised how burdensome publication would prove in light of the sheer volume of contracts being put in place but in any event it is unlikely that the making of legislative changes (e.g. to simplify this process) would have been considered viable at the time.

1.37 No procurement process, particularly a process such as the procurement of PPE conducted, out of necessity, on such a scale and at such speed, can totally eliminate fraud. Some suspected cases of attempted fraud in PPE buying were referred to the DHSC departmental fraud officer and his team. At my request, the Government Counter-Fraud Function carried out a review of checks used in the PPE buying process at the beginning of May 2020. The findings of this review are summarised and exhibited at paragraph 5.26.

(vi) Commercial structures

1.38 In response to the challenges described above, commercial structures introduced during the five years before the pandemic - the set up of the GCF and GCO - allowed trained resources to be moved rapidly to the point of greatest need. As an example, experienced commercial staff from MoD Defence Equipment and Support (DE&S) took key roles in PPE buying within the Parallel Supply Chain organisation set up by DHSC, as did many experienced commercial staff from the Department for Education, the NHS and other public bodies, increasing the size of the overall central team buying PPE from 22 to around 500.

1.39 As I stated in my witness statement[18] for Module 1 of the Inquiry, the GCF as a whole was not instructed to prepare for public procurement in the event of a whole-system civil emergency or a pandemic prior to January 2020. Nonetheless, the functional model of working and the ability to use existing legal flexibilities to procure at speed ensured that GCF was able to respond to challenging commercial demands. Lord Agnew volunteered help in the form of experienced commercial personnel (as described in paragraphs 4.154 and 4.280) from the Cabinet Office on 16 March 2020 and DHSC and the NHS accepted these offers.[19] Staff were deployed into PPE and Testing within days of receiving this request for help.

1.40 Large numbers of commercial staff were mobilised to new roles to buy many things including ventilators, PPE and testing equipment. They achieved remarkable results. The *structure* of the GCF, therefore, which has been built incrementally over the last eight years, (including the employment model, the flexible pool of specialists in CTT and the accreditation process) helped greatly in moving properly qualified and experienced commercial staff to the point of need (see Section B below).

[18] GRW/2 - [INQ000182611]
[19] GRW/15 - [INQ000496694]

1.41 Planning for leaving the EU on 31 January 2020 had some useful, if unintended side effects: it drew attention to the vulnerability of some supply chains to trade disruption, including medicines and PPE. In addition a quantity of medical gloves were bought as a contingency against such disruption (see para 4.294.2). This planning work was completed before significant effort was concentrated on the pandemic. The EU Commission (DG Santé) initiated a number of joint procurements during the pandemic including for PPE and ventilators. It was for DHSC to decide whether or not to join these procurements, and in any event I understand that for PPE the joint procurements understandably met with difficulties (see paragraph 6.11).

1.42 It was thought that UK sovereign capability (onshore manufacturing) was an answer to supply chain resilience, and such capability was established for both PPE and LFTs. If the object of onshoring is to ensure the supply of these critical goods is under the control of the Government (and not subject to transport disruption, or export restrictions or, as happened, a disease outbreak in a producing country) then we also need to ensure the supply of all the relevant raw materials. During the pandemic these raw materials became very scarce, and some governments restricted the export of some key ones to support local needs. We were able to repurpose production lines that made simple low density polyethylene (LDPE) products such as bin liners to make basic aprons by investing in appropriately shaped cutting tools, a relatively simple task. Gowns however are made from complex meltblown fabrics which are made on machines costing millions of pounds that are largely located in China (where the factories ran out of capacity). Consequently, setting up the cutting and sewing lines to make gowns in the UK only solved part of the problem - the choke point was still the meltblown material that largely came from overseas.

1.43 Additionally, as I explained in my Module 1 statement, “if we do not want to run out of product at times of high surges in demand, unless the supply chains are very flexible, we need to accept the cost, year on year, of considerably higher stockpiles of those key items than we have been prepared to pay for in the past, and we need to avoid running those stockpiles down, to avoid handling costs, without considering the effect of these rare events. The year-on-year costs of these actions make these decisions very difficult.”[20] Particularly as in the case of PPE, where the shelf life of many of the products was a few years (usually 2-5 years) whereas we would have needed a stockpile of perhaps 17 years ‘normal’ supply to cover our needs. Redesigning products to extend their shelf life is not an easy task, and not doable in the time frame

[20] GRW/2 - [INQ000182611]

of a pandemic; it also invites suspicion from users, and to the extent that technology subsequently advances, risks rendering very large stockpiles technically obsolete. It is also costly to install and maintain production capacity sufficient for the 'surge' demand of a pandemic, while only using it at normal, much lower volumes outside of a pandemic.

Structure of this statement

Overview of structure and responsibilities

1.44 Section B of the statement introduces and provides an overview of the GCF, the pan-Government network of around 6,000 civil servants in central government departments and led from the Cabinet Office. These civil servants have a role in both procuring and providing the necessary capacity to support the procurement of goods and services on behalf of the Government. This section will also explore the operational structure and governance of the GCF, including the Crown Commercial Service (CCS), the Central Commercial Teams (the 'CCTs'), Other Government Departments' ('OGDs') commercial staff, and that of the GCO. This section will also address the work of the GCF in respect of best practice guidance and support to OGDs throughout the pandemic in the issuing of a number of Procurement Policy Notes ('PPNs') and the convening of monthly meetings of the Commercial Function Leaders Group - attended by officials and representatives from OGDs, various arm's length bodies (ALBs), the NHS and the devolved administrations - which were generally chaired by myself.

1.45 The CCTs sit within the Cabinet Office and report directly to the GCCO. A number of these teams had key roles in the Government's COVID-19 response. Staff wrote policy instructions, were deployed to lead commercial projects contracted for by other departments, provided market insight and due diligence checks, undertook assurance and operated spend controls, and fielded thousands of enquiries from businesses offering help to Government.

1.46 Cabinet Office has operated a Commercial Spend Control using spending powers delegated from HM Treasury since 2011. Under these powers, each new contract over a threshold value (in 2020, £10m) was triaged by a Cabinet Office official working within the Commercial Continuous Improvement team. Submissions that were assessed as being novel, contentious, or repercussive or otherwise raising concerns were examined in more detail. For the most significant contracts, that official produced advice for a Cabinet Office minister on whether the commercial approach to the

contract complied with standards and commercial best practice for ministerial approval. Not all contracts are subject to the controls. Exemptions are set out in the controls policy on gov.uk (current and historic versions exhibited).[21]

1.47 To meet the need for extreme urgency in responding to COVID-19, the Cabinet Office offered a 48-hour turnaround to teams seeking approval for relevant purchases.[22] On 22 April 2020 DHSC, which was by then in receipt of regular budget allocations for PPE from HMT, requested alternative arrangements as, due to the volatility of the market, in even 48 hours prices could change or orders be lost. Given the critical need to procure at speed, advance approval of PPE spend over £10m was suspended on the basis of the conditions that HM Treasury had set when releasing the PPE budget to DHSC.[23] Retrospective approval of this approach was confirmed by Lord Agnew in May 2020.[24] A further adjustment was made on 28 August 2020 to raise the threshold for Test and Trace and Vaccination cases to £100m.[25]

1.48 One of the changes made to help streamline the controls (outside of PPE and vaccines), while still ensuring the best commercial advice was brought to bear, was the introduction of the Spend Control Panel to review 'contentious' cases.[26] Along with the Minister (Lord Agnew), membership of this panel included the GCCO and Cabinet Office Permanent Secretary. Officials attending this panel were there to advise the Minister. In the 10 months to February 2021 it was estimated that the panel processed cases comprising £133 billion of proposed expenditure.[27]

Procurement principles, procedure and policy

1.49 As robustness of oversight, transparency and value for money are at the heart of the work of the GCF, Section C of the statement will address the various policies and procedures which underpin the procurement of goods and services on behalf of the Government. This section will refer to a number of policy and guidance documents which apply to government procurement and will also refer briefly to the legal and regulatory environment within which procurement operates. This section will also provide a high level overview of the declarations of interest process and set out how

[21] GRW/16 - [INQ000471068] - Version 5, GRW/17 - [INQ000471066] - Version 6, GRW/18 - [INQ000471067] - Version 7
[22] GRW/19 - [INQ000496708]
[23] GRW/20 - [INQ000496709]
[24] GRW/21 - [INQ000496906]
[25] GRW/22 - [INQ000473893]
[26] GRW/23 - [INQ000477936]
[27] GRW/24 - [INQ000477946]

conflicts of interest are managed, concepts which will be discussed in greater detail throughout the statement.

1.50 Procurement is a devolved matter (i.e. procurement by devolved bodies is the responsibility of the devolved administrations, the Northern Ireland Assembly, the Welsh Parliament and the Scottish Parliament). During the response to the pandemic all public procurement activity in England, Wales and Northern Ireland was subject to the provisions of the 2015 Regulations (and separate, substantially equivalent regulations in Scotland). For defence and security procurements, the Defence and Security Public Contracts Regulations 2011 (DSPCR (2011)) applied across the UK.

1.51 The 2015 Regulations transposed into national law the provisions of relevant EU directives on public procurement. Scotland had chosen to implement the Directives with its own regulations (the Public Contracts Regulations (Scotland) (2015))[28], while maintaining the principles of equal treatment, transparency, non-discrimination and proportionality that are the underpinning of the UK regime.

1.52 The 2015 Regulations include provisions for the use of accelerated procedures in a state of urgency, and in regulation 32(2)(c), the award of public contracts by a "negotiated procedure without prior publication". This procedure can be used to award contracts without applying the usual competitive procedures (including by direct award). On 18 March 2020, the Cabinet Office Commercial Policy Team issued a Procurement Policy Note (PPN 01/20) 'Responding to COVID-19'[29] advising public bodies on how to use these emergency provisions in response to COVID-19.

1.53 Section D of the statement will address some of the core workstreams that are to be considered by the Inquiry in Module 5: ventilators, PPE and testing.

Ventilators

1.54 In the early stage of the pandemic, evidence from Italy and other countries made it clear that the most severely affected COVID-19 patients would require ventilation or other assistance with their breathing. At the beginning of the emergency it was estimated that there were around 7,000 ventilators available to the NHS. Worst case estimates at that stage suggested that more than 60,000 (and perhaps up to 90,000) such devices might be needed at the peak of the epidemic. These estimates were provided by DHSC/NHS and are evidenced from paragraph 4.3 with further detail on targets from paragraph 4.69.

[28] GRW/25 - [INQ000496753]
[29] GRW/26 - [INQ000048822]

1.55 The Government's response on ventilators had two workstreams.

1.55.1 The first was to obtain ventilators from the international market and from other healthcare providers. The Accounting Officer and responsible Minister for this workstream were in DHSC.

1.55.2 The second, initiated by the Cabinet Office on 13 March 2020, was to encourage UK-based businesses to design and increase capacity to manufacture mechanical ventilators at scale and with urgency. This was the 'Ventilator Challenge' and was announced by the Prime Minister on 16 March 2020. 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. The responsible Minister was Lord Agnew. This project successfully delivered 15,000 ventilators for use in the NHS within 4 months of inception, compared to the 4.5 years it would normally take to design, develop, approve and produce a medical product of this sort. I understand from NHS England's public statements that even at the height of the pandemic there was no shortage of ventilators and intensive care, and the Ventilator Challenge will have played a role in that.[30] Further information on the process and spend relating to this project is set out in Section D(i).

Testing

1.56 Section D will also explore the role of the GCF in the NHS Test and Trace programme from its early iterations in March 2020 (when it was referred to as the Test, Track, Trace and Certify Programme), then in NHS Test and Trace which was established under the leadership of Baroness Harding in May 2020, and up until March 2021, when NHS Test and Trace had a commercial unit of its own led by Jacqui Rock (an employee of the GCO).

1.57 On 18 March 2020, as requested by DHSC, Cabinet Office officials from the GCF were deployed to lead procurement activity in support of building mass testing capacity in the UK. Up to 25 GCF staff were quickly engaged and, under the direction of DHSC officials, conducted the majority of the buying activity to build a national network of testing laboratories and subsequently to secure large numbers of lateral flow tests. Members from this team continued working with NHS Test and Trace until March 2021.

[30] GRW/27 - [INQ000496764]

1.58 The SROs and the Accounting Officer for Test and Trace were all DHSC officials, and governance was exercised through working groups reporting to Lord Bethell, DHSC Minister for Technology, Innovation and Life Sciences. The Cabinet Office officials in the Test and Trace commercial team also had a dotted-line responsibility to the GCCO, and gave a frequent written update to the GCCO on this critical project. An example of one of these updates is exhibited.[31]

1.59 The Inquiry has expressed interest in the purchase of capacity to conduct Reverse Transcription - Polymerase Chain Reaction (RT-PCR) tests and the purchase of LFTs.

1.60 In March 2020 only NHS pathology laboratories, a few research sites and public health laboratories in the UK had the ability to test for COVID-19, using what was then considered to be the 'gold standard' for testing, RT-PCR. Total testing capacity was estimated at 6,000/day notionally and 3,000/day in practice. To run an effective national test and trace programme, planners estimated that this capacity in practice needed to be 100,000/day by end April 2020 with further expansion to 200,000/day by end May 2020. Although some expansion could be achieved by building around existing equipment, personnel and facilities, this 30-fold expansion demanded a radical rethink.

1.61 A call to industry was made on 2 April 2020 by the Secretary of State for Health and Social Care to ask for contributions to this effort.[32] The commercial testing team led by GCF personnel from the Cabinet Office awarded contracts to build a network of 'Lighthouse Labs', which were responsible for providing a testing service from reception of samples to generation of test results. Overseas laboratories were also contracted to provide surge capacity. At the same time the publicly-owned testing capacity was increased by repurposing some laboratory space, and the commercial testing team bought equipment and consumables in an increasingly tight international market. The commercial testing team also contracted for a logistics system to get samples from testing sites and other sources to labs.

1.62 By the end of October 2020 testing capacity exceeded 500,000 RT-PCR tests/day and by the end of 2020, capacity existed to undertake 750,000 tests/day.[33]

1.63 In summer 2020 antigen LFTs became available. Antigen tests look for signs of the virus itself rather than antibodies, which are produced by the patient as a response to infection by the virus. These antigen tests had lower sensitivity and specificity than the

[31] GRW/28 - [INQ000496711]
[32] GRW/29 - [INQ000477280]
[33] GRW/30 - [INQ000287601]

'gold standard' RT-PCR tests, but could be self-administered in the home and gave a result in 30 minutes rather than the 24 hours required to collect a PCR sample, ship it to a laboratory, conduct a test and analyse and return a result. The testing strategy was to use LFTs on asymptomatic patients and then follow up with a confirmatory RT-PCR test. RT-PCR was considered to be the best test for symptomatic patients.

1.64 By May 2021 655m LFTs had been distributed, including to institutional and healthcare settings. LFTs had also been offered free of charge to members of the public.

1.65 In October 2020 NHS Test and Trace set up a project to establish LFT manufacture in bulk in the UK. The Cabinet Office contributed a commercial director to this team, reporting to a commercial director in NHS Test and Trace. Before the project started the UK had a small specialist capacity to manufacture antibody LFTs, estimated at 0.4m tests/week, and no certified antigen tests were made in the UK. By January 2021 a UK factory had started delivering LFTs to the NHS, and capacity was increased by May 2021 to 5m tests/week. Further detail on this project is given in paragraphs 4.261 onwards.

PPE

1.66 Section D finishes by exploring the role of the GCF in providing staff to help set up the Personal Protective Equipment ('PPE') Parallel Supply Chain in March 2020 and in taking on management and other roles, under the direction of DHSC, in the first four months of the supply chain's existence.

1.67 The nature of COVID-19 greatly increased the need to use PPE in a wide range of healthcare, social care and non-healthcare settings where it had not routinely been used before.

1.68 At the same time the market for PPE became severely disrupted and on one estimate demand for some items of PPE increased by 30 times.[34] China is by far the largest exporter of PPE worldwide. China was itself experiencing a severe COVID-19 outbreak which led to lockdowns, reducing its manufacturing capacity while diverting residual production and stock towards local use, and also imposing some export restrictions. In addition, shipping arrangements were disrupted as carriers stopped travelling to the country. Simultaneously healthcare providers and other purchasers

[34] GRW/31 - [INQ000471055]

worldwide put enormous new demands on the market, and some other countries also responded with export bans.[35]

1.69 While the DHSC had stockpiles of PPE it was clear in early 2020 that these would only last for a short period. Existing buying and distribution arrangements (including through the DHSC-owned company, Supply Chain Coordination Limited (SCCL), trading as NHS Supply Chain) rapidly proved not to be adequate to cope with the dramatically increased demand.[36] In Section D of this statement, I describe how DHSC, with significant assistance of Cabinet Office GCF officials, set up a Parallel Supply Chain for the purchase, import and distribution of PPE. This Parallel Supply Chain allowed DHSC to place contracts for 17 billion items of PPE,[37] primarily between March and July 2020. The Senior Responsible Officer (SRO) and the Accounting Officer (AO) for the activity were DHSC officials and DHSC had the ministerial responsibility.

Fraud

1.70 Section E of this statement will set out how procurement practices and procedures serve to militate against the risk of fraud. This section will outline the work that was undertaken by the Government's Counter Fraud Function, based in the Cabinet Office, which supported the DHSC with counter fraud advice in respect of pandemic related procurement. This work complemented the extraordinary measures put in place to address the exceptional volumes and urgency of pandemic procurement, which are explained throughout Section D.

Internal and External Reviews

1.71 Section F addresses the various internal and external reviews that have been undertaken to learn lessons from the experience of procurement during the pandemic. These reviews are exhibited throughout the section. Section F includes a description of internal work undertaken at the time and shortly after, to assure Ministers and senior officials that appropriate procurement processes had been applied; for example that pricing did not favour certain suppliers and that viable offers had not been overlooked.

1.72 Several internal reviews of COVID-19 procurement have been commissioned by the Cabinet Office. Several of the projects captured 'lessons learned' during or immediately after the conclusion of the buying activity. Two Government Internal Audit

[35] GRW/32 - [INQ000105495] and GRW/33 - [INQ000083726] provide a picture of the export bans that were put in place
[36] See paragraph 4.279 onwards
[37] GRW/34 - [INQ000475559]

Agency (GIAA) audits of PPE purchasing were commissioned by the Permanent Secretary of the Cabinet Office,[38] and in 2021 Sir Nigel Boardman was asked by the Prime Minister to review COVID-19 procurement.[39] A review was also undertaken of international comparators in 2021, when audit reports of similar activity overseas became available.[40]

1.73 Formal internal audits were carried out by GIAA in two tranches between August 2020 and February 2021, each looking at 6 PPE contracts that had attracted press comment on how they were awarded. The reports included contracts that were processed by the HPL and those that were not. The reports found that, while there were shortcomings in the level of documentation available, the contracts examined had generally been awarded within the defined controls framework (a documented system of checks within the buying process). The workflow system (Mendix, something that was put together rapidly to track the inflow of PPE offers following the 'call to arms'), while it did collect many details on each offer, did not contain all the data needed to establish this and consequently extensive work was required by GIAA to find other data in emails and spreadsheets. The report confirmed that the auditors had not found evidence of preferential treatment.

1.74 Sir Nigel Boardman initially reviewed the award of certain communications contracts in the Cabinet Office ('Boardman 1'). A subsequent review of COVID-19 procurement ('Boardman 2') was carried out in 2021. It looked at procurement activity generally and conducted interviews with several of the practitioners who had done the buying, as well as the GCCO and other senior officials who had overseen it. Boardman 2 produced 28 recommendations in relation to each of the two reviews, which were all accepted by the Government, and of which all except two are complete, including those that were the responsibility of the Cabinet Office. Further detail on implementation of the recommendations is provided in paragraph 6.35 and from paragraph 6.47 onwards.

Procurement Act 2023

1.75 Section G provides an overview of the Procurement Act 2023 (the '2023 Act'). Following the departure of the UK from the EU, the opportunity arose for the UK to diverge from the relevant directives, seeking greater efficiency and value for the money spent in public procurements every year (c.£300 billion). The proposals for a revised

[38] GRW/35 - [INQ000478823], GRW/36 - [exhibit to follow]
[39] GRW/37 - [INQ000055876]
[40] GRW/38 - [INQ000496743]

regime included new powers for Ministers to make regulations to allow for the direct award of contracts in an emergency. These proposals were first published in a Green Paper[41] in December 2020 and refined in response[42] to the consultation published in December 2021. The Procurement Bill received Royal Assent on 26 October 2023 and became the Procurement Act 2023. The 2023 Act is expected to come into force on 28 October 2024.

1.76 As well as detailing some of the differences between the 2023 Act and the 2015 Regulations, this section outlines how the experience of procurement during the pandemic - particularly in respect of executing procurements during times of extreme urgency, the need to ensure increased transparency of procurement decisions while still efficiently operating under urgent procedures and the need to enhance conflict of interest protections - influenced the policy behind the 2023 Act.

1.77 The provisions in the 2023 Act go beyond those in the 2015 Regulations. The 2023 Act allows for direct award of contracts in extreme urgency, similar to the 2015 Regulations, and requires publication of additional notices in such situations, thereby increasing transparency whilst maintaining a simplified process. The 2023 Act also includes new powers for a Minister to 'declare' an emergency by making regulations which allow for the direct award of certain types of contracts in particular situations (removing the requirement for individual contracting authorities to justify the use of a direct award for each contract and publish the justification).

Concluding remarks

1.78 Section H provides brief concluding remarks for the Inquiry's consideration.

[41] GRW/39 - [INQ000475569]
[42] GRW/40 - [INQ000471033]

2. SECTION B: OVERVIEW OF STRUCTURE AND RESPONSIBILITIES

2.1. Before turning to the specific procurement functions, it is of course important to note that the Cabinet Office's role more broadly (as described on gov.uk) is to "support the Prime Minister and ensure the effective running of government. We are also the corporate headquarters for government, in partnership with HM Treasury, and take the lead in certain critical policy areas". The Cabinet Office has responsibility for[43]:

2.1.1. "supporting collective government, helping to ensure the effective development, coordination and implementation of policy";

2.1.2. "supporting the National Security Council and the Joint Intelligence Organisation, coordinating the Government's response to crises and managing the UK's cyber security";

2.1.3. "promoting efficiency and reform across government through innovation, better procurement and project management, and by transforming the delivery of services";

2.1.4. "promoting the release of government data, and making the way government works more transparent";

2.1.5. "creating an exceptional Civil Service, improving its capability and effectiveness; and,

2.1.6. political and constitutional reform".

2.2. The Cabinet Office, and the agencies and public bodies which support it, contain a wide range of other activities, as well as a number of cross cutting Functions which enable the delivery of government. These Functions are led by the Permanent Secretary for the Cabinet Office (which, at the beginning of the relevant period, was John Manzoni before Alex Chisholm took up this post in April 2020). These other functions, with the exception of the Government Commercial Function and the Government Counter Fraud Function, are not addressed by this statement.

2.3. The focus in this statement is on the specific areas of activity that the Cabinet Office undertook on procurement during the relevant period which have been identified by the Inquiry. Core decision-making and the strategic response to the pandemic that was overseen by the Cabinet Office including No.10 informed procurement priorities for the government as a whole throughout the evolution of the pandemic response.

[43] GRW/41 - [INQ000471035]

Government Commercial Function

2.4. This section of this corporate witness statement draws on and repeats material included in my witness statement prepared for Module 1 of the Inquiry.

2.5. The mission statement of the GCF since 2016 has been to: "enable government departments and the wider public sector to deliver their aims at best value for UK citizens". Members of the GCF, based in commercial teams across government, acquire goods and services on behalf of public bodies, facilitating the implementation of government policy. They manage relationships with suppliers in the private sector and oversee the portfolio of contracts with those suppliers. Working with Departmental contract managers, they ensure that goods and services are delivered by suppliers in line with those contracts and in full support of the activities of their customers. In addition, the GCF has responsibility for procurement policy generally including reform of the legal framework within which public procurement happens, and through CCS, providing a facility for the wider public sector to take advantage of government's buying power.

2.6. While there have always been individual commercial teams in government departments, awarding (sometimes called 'letting') the contracts needed to deliver each department's agenda, the GCF was brought into being as a pan-government network in 2014, following a range of well-publicised procurement failures. Analysis at the time determined that commercial efforts suffered from:

2.6.1. poor retention of suitably qualified staff due to limited career paths and inappropriate pay levels, resulting in loss of staff to the private sector and the inability to recruit well;

2.6.2. inconsistent commercial methods and a lack of commonly agreed standards across different departments; and

2.6.3. a lack of integrated supplier management.

2.7. The establishment of the GCF was accompanied by further structural changes, namely: the appointment of the first Government Chief Commercial Officer, and the creation of the CCS.

2.8. Private sector corporates have used a functional model for several decades and in general they are effective at:

2.8.1. ensuring the provision of required professional capability;

2.8.2. identifying and implementing best practice ways of working across federated organisations; and

2.8.3. leveraging these two to continuously improve desired outcomes and results through benchmarking.

2.9. The GCF was set up with these objectives in mind.

2.10. After a number of small changes to make accountabilities clearer, the structure of the GCF has been stable since 2017. It comprises:

2.10.1. The Central Commercial Teams (CCTs): there are a number of teams based in the Cabinet Office that execute tasks on behalf of the wider function that are best done centrally on behalf of the function as a whole. The CCTs are funded from the Cabinet Office's budget.

2.10.2. The Crown Commercial Service (CCS): a trading fund, which establishes frameworks for 'common goods and services' categories that all departments are likely to buy: Buildings, Technology, Business Services and People. For example, energy can be most efficiently purchased by the Government acting as a whole, rather than by individual departments.

2.10.3. Commercial teams in departments: the majority of commercial staff are based in departments, or their arms' length bodies (ALBs), executing contracts for items or services that are bespoke to that department - for example, there are commercial staff in the Ministry of Defence (MoD) buying military equipment.

Central Commercial Teams: *based in the Cabinet Office*

2.11. The CCT is the collective title given to the specialist commercial teams which sit within the Cabinet Office, reporting directly to the GCCO. At the start of the pandemic they were configured as:

2.11.1. GCCO private office: supporting the GCCO.

2.11.2. Strategy, Assurance and Standards (formerly Commercial Continuous Improvement): responsible for Commercial Assurance of departmental contracts, the setting of functional Standards, and the Benchmarking and Masterclass work that shares identified best practice across the GCF. During the pandemic, the Cabinet Office was required to adapt this control

mechanism to meet the demands of the emergency. In some cases (for example for PPE) the Commercial Spend Controls were suspended and subsumed within HM Treasury's approvals for such spend.

2.11.3. Commercial Policy: responsible for the reform of procurement regulations, providing procurement policy advice to Ministers, and for implementing approved policy changes, for example on the amount of public spend that goes to SMEs. Outside of regulatory changes, this is done by using the well-established process of policy-making and issuing of Procurement Policy Notes (PPNs) and other guidance to the commercial teams throughout the public sector. That commercial staff across the public sector were used to disseminate and implement PPNs was important in the pandemic when a number of new and novel initiatives had to be rapidly adopted. Further information on PPNs during the pandemic is provided in Section C.

2.11.4. Markets and Suppliers: responsible for the management of the 40 Strategic Suppliers, that in general supply multiple departments or have the largest revenues, and the monitoring of a further group of some 150 key suppliers. A team of full-time civil servants work alongside 15 ‘Crown Representatives’; senior executives from industry, usually in the portfolio stage of their careers, who work part time to improve the performance of the particular Strategic Supplier to whom they are allocated.

2.11.5. Sourcing: responsible for the generation and implementation of commercial “Playbooks”. These are best practice guides on an industry sector-by-sector basis co-developed with industry in order to improve how contracts in that particular sector are negotiated and let. (Since the pandemic ended, this team has been merged with the Markets and Suppliers team.) The core Playbook, on which the others are based, is the Sourcing Playbook which is aimed primarily at, and should be complied with by, central UK Government departments and associated ALBs. Nevertheless, the intent is that all public sector contracting authorities should consider the policies and principles it sets out, including those in the devolved administrations. The Cabinet Office currently produces four playbooks: Sourcing, Consultancy, Construction, and Digital, Data and Technology (DDaT). While these playbooks do not specifically consider emergency procurement (or direct awards), there are examples of

commercial good practice that would be helpful in any procurement situation.

2.11.6. Complex Transactions: responsible for providing expert support for high value negotiations and disputes, an experienced team of around 35 staff, mostly Senior Civil Servant 1 (SCS1) level, who act as internal consultants, employed by the Cabinet Office and typically recharged on a day rate to the Departments whose projects they are working on, usually for a period of a few months before being reassigned to the next project. The existence of this pool of highly skilled commercial staff, available for deployment into departments and ALBs across government, and used to working in that way, was to prove crucial during the pandemic when we had to rapidly provide resources and leadership for multiple new commercial teams.

2.11.7. Commercial Capability: responsible for attracting, retaining, developing, accrediting and rewarding senior commercial staff in the GCO and in the wider public sector. At the time the pandemic started the Capability team was also ramping up the training and accreditation of Contract Managers, usually a different group of colleagues from the GCF.

The Crown Commercial Service (CCS)

2.12. The purpose of the CCS is to help UK Government departments, ALBs and the wider public sector get better value for money from their purchasing in categories of goods and services where multiple public sector organisations have the same requirement in common. It does this in a number of ways, particularly:

2.12.1. By putting in place commercial agreements (framework agreements and dynamic purchasing systems) with capable suppliers which leverage the public sector's collective buying power and enable fast, effective and compliant procurement by public sector organisations.

2.12.2. By deploying expertise in certain categories of goods and services to shape and understand markets and advise public sector customers.

2.12.3. By providing an assisted procurement service, primarily but not exclusively, to central government departments, running "call-off" procurements primarily from CCS framework agreements on their behalf.

2.12.4. By developing digital solutions and platforms which simplify and facilitate the public procurement process.

Staff based in Other Government Departments

2.13. One of the unique features of the GCF is that the senior commercial professionals within it are centrally employed by the Cabinet Office but then deployed on a long term basis to Departments (and the CCS), including to the Cabinet Office's own commercial team, (which at the time was led by Tim Rogers reporting to the Cabinet Office's Chief Operating Officer). This Government Commercial Organisation (GCO) was set up to particularly address the skills shortage, training and retention issues referred to above. The GCO contains all central government commercial staff at Grade 7 (G7, 'Commercial Leads') and above: currently in the region of 1,500 staff. These senior commercial professionals are normally paid through Cabinet Office payroll and their salary costs recharged to the Departments by the GCO. They then manage the 4,500 less senior commercial staff who are employed and directly paid by their departments in the normal way.[44]

2.14. The GCO includes those commercial staff that sit within the Complex Transactions Team (CTT) (described above). These officials are allocated, on a short term basis, to Departments who have a complex transaction to undertake as and when the need arises. Each CTT staff's authority when on an engagement with another Department is role-dependent and conferred by that Department. When on engagement the CTT staff have no authority flowing from their membership of CTT.

2.15. Roles of CTT staff are most often operational, working on high profile advisory and delivery work. CTT staff work with programme and commercial teams to deliver commercial strategies, negotiations and disputes, often planning and conducting the more complex negotiations. This assignment is normally agreed by way of a formal letter of engagement. One of the reasons for the letter of engagement is to agree scope and fees and allow for the cross-charging of staff, whereby a purchase order is raised against the engagement letter to enable the Cabinet Office to invoice. When a department requires further consultancy or temporary commercial resource than the CTT has available, the CTT supplements its resources with staff provided by private companies under standing consulting agreements, called co-sourcing. For example, during the relevant period, on PPE the principal co-sourcing company was Baringa. Further information about Baringa and its role in providing additional resources to

[44] GRW/42 - [INQ000101268]

supplement the CTT team working in the PPE Buy Cell is provided in paragraph 4.313.2.

2.16. GCO commercial staff receive higher pay compared to the standard offered to most civil servants; approximately a 20% salary uplift and higher maximum bonus opportunity, offset by not being eligible for the standard civil service pension, instead receiving a 3% defined contribution pension. To qualify for this enhanced pay offer two things have to be in place:

2.16.1. Each Department has to complete and maintain a signed-off 'organisational blueprint', laying out the number and grade and speciality of commercial staff required to execute that Department's commercial agenda, as expressed through a documented 'commercial pipeline' of activity. It is benchmarked against the private sector and reviewed every 2 years or as needed, and to be valid needs to be signed off by the Department's Commercial Non-Executive Director and Permanent Secretary, the HM Treasury Permanent Secretary, the GCCO and the Permanent Secretary of the Cabinet Office.

2.16.2. Each individual employee wishing to work at a senior level in the commercial function needs to pass the GCO's Assessment and Development Centre (ADC) accreditation at the relevant level in order to demonstrate their commercial competence. That accreditation has to be kept valid by completing a stipulated amount of continuing professional development per year.

2.17. This has ensured that commercial staff in departments, at least at G7 and above, are demonstrably competent and that each Department's commercial team is appropriately resourced to deal with that Department's anticipated workload. Furthermore, because all members of the GCO have undertaken and passed the ADC, there is a high degree of mutual confidence and trust that has allowed the sharing of supplier and contract information and best practice that was not previously achievable.

2.18. The central employment of GCO members has made it easier to ensure that:

2.18.1. senior commercial staff continue with their continuous professional development;

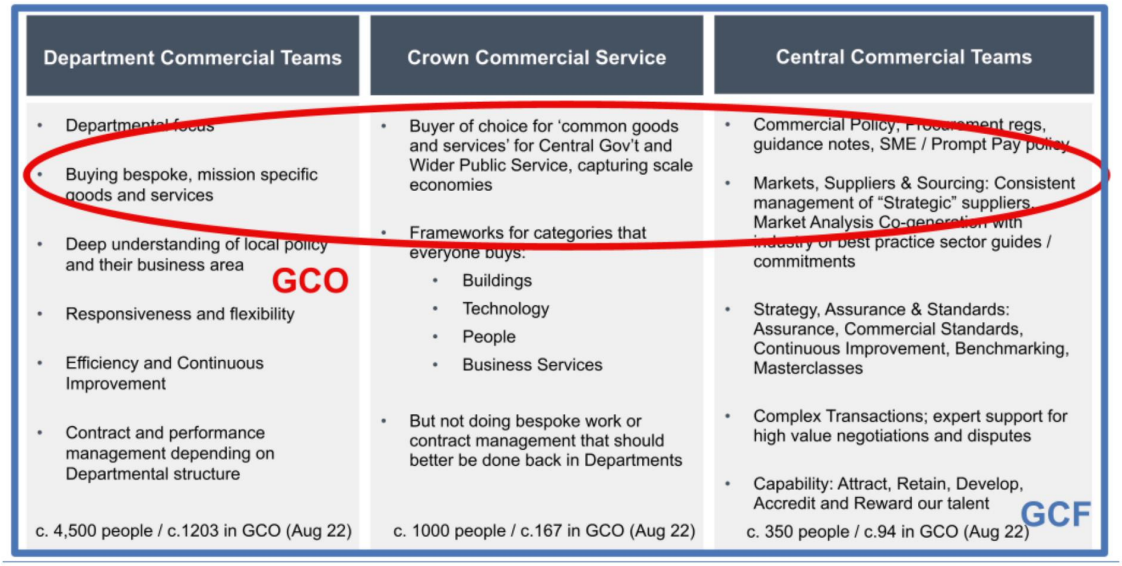
2.18.2. senior commercial staff are able to follow a career path not just in one Department but across the wider commercial function; and

2.18.3. good practice is shared across the function. This is achieved by the use of collectively agreed Commercial Operating Standards and Commercial Professional Standards against which departments are benchmarked. The GCF then runs Masterclasses to share the best practice that has been identified by those league tables, thus improving the performance of the entire function and avoiding siloed practices.

2.19. The GCF has instituted a rolling 3-year Functional Plan with circa 10 improvement projects running across the function at any one time, resourced by people across the function. Because of these ongoing cross departmental activities, members of the GCO in particular, but also the wider GCF, are used to operating together as a combined commercial function, delivering more than the sum of their individual parts. This is demonstrated by the improved contract outcomes, improved retention and training levels, and year-on-year savings that the commercial function has been able to deliver.

2.20. The structure of the GCF is represented in the table below. The red circle captures the GCO and how it sits across the three pillars.

Structure of the Government Commercial Function



Governance of the Government Commercial Function

2.21. The governance of the GCF has two elements in that most people that work in the GCF are working principally in and for their Department. Their objectives are set mainly by their departmental line manager in accordance with those being pursued by

the leadership of that Department. The role of the function is to ensure those objectives are executed in the most commercially effective way, not to set the objectives.

2.22. Departments determine 'what' contracts are needed to support their policy objectives, with the advice of their commercial teams. This work is led by the local Commercial Director in each Department, usually directly reporting to the departmental Chief Operating Officer (COO), who usually reports to the Department's Permanent Secretary. To ensure consistency of approach and knowledge sharing, the Commercial Director in each Department also reports functionally to the GCCO who will set them a small number of cross-function objectives each year. In this way the GCF works to improve 'how' that departmental requirement is delivered.

2.23. The governance of the GCF is as follows:

2.23.1. The Central Commercial Teams report directly to the GCCO, who reports to the Cabinet Office Permanent Secretary and Chief Operating Officer for the Civil Service, which was Alex Chisholm for the majority of the pandemic. Alex Chisholm reported to the Minister for the Cabinet Office, whereas normally the GCCO reports to a junior Cabinet Office Minister. During the majority of the pandemic, the GCCO reported to Lord Agnew, Minister of State for the Cabinet Office.

2.23.2. As above, Commercial Directors in departments work functionally to the GCCO.

2.23.3. The GCO has:

- An Oversight Committee that oversees the operation of the GCO and the delivery of the Commercial Functional Plan. Chaired by a departmental permanent secretary, membership is typically made up of departmental CCOs, the chair of the GCO customer committee, and the Government Chief People Officer.

- A Customer Committee made up of a subset of commercial representatives from Departments, chaired on an annually rotating basis by one of the departmental commercial directors. Its remit is to ensure that the GCO is delivering the numbers of trained and accredited staff that Departments need to staff their agreed organisational blueprint.

- An Accreditation Committee made up of a number of senior commercial staff in Departments, supplemented with independent commercial experts, chaired by the director of commercial capability. Its remit is to ensure that the accreditation is fair, unbiased and consistent over time.

2.24. The 'Commercial Function Leaders Group' (CFLG), chaired by the GCCO, meets every month to discuss items of common interest, monitor implementation of the GCF Functional Plan projects and agree on any required actions. Attendees are the Commercial Directors from departments and ALBs and the NHS as well as the CCT Directors.

2.25. To ensure the departmental permanent secretaries are kept informed of commercial issues, the Civil Service Board receives annual and 'as required' updates from the GCF, in addition to direct communications on urgent commercial issues.

Commercial Spend Control and Assurance

2.26. Beyond the functions of the GCF outlined above, the Commercial Spend Controls process is operated by the Cabinet Office Central Commercial Teams (CCTs) which are part of the GCF. Cabinet Office Ministers and officials have roles in the assurance of some high value procurement decisions taken by contracting authorities. Such review is provided by the Cabinet Office through the Strategy, Assurance and Standards Team (a CCT) at official level as part of the operation of the Commercial Spend Controls. These officials make a recommendation to a Cabinet Office Minister regarding whether the spend should be accepted, rejected or accepted with conditions. The Cabinet Office ministers who held this responsibility for the relevant period were Jeremy Quin (Parliamentary Secretary in the Cabinet Office), from 2019 until 14 February 2020; Lord Agnew (Minister of State at the Cabinet Office and Her Majesty's Treasury) from 14 February 2020 to 24 January 2022; and Jacob Rees Mogg (Minister of State) from 8 February 2022 to 6 September 2022.

2.27. Cabinet Office Commercial Spend Controls currently apply to all commercial activity with a value of £20m or more, excluding VAT, with some exceptions for the larger, more commercially mature programmes. Until February 2023 this threshold was £10m when it was changed as part of wider reforms. There is a presumption that all central government organisations are subject to all of the Spend Controls (unless specifically excluded at formation e.g. through the founding legislation).[45] In exceptional

[45] For example, the list of organisations exempt in January 2020 were published on gov.uk: GRW/43 - [INQ000496754]

circumstances, exemptions may be granted to organisations within scope with respect of some or all of the Spend Controls. Organisations may request an exemption from the Cabinet Office and these are considered on a case-by-case basis and must be approved by Cabinet Office and HM Treasury ministers.

2.28. The Commercial Spend Controls are delegated from HM Treasury, which retained oversight of all COVID-19 spending. During the pandemic, the Cabinet Office was required to adapt this control mechanism to meet the demands of the emergency. In some cases (for example for PPE) the Commercial Spend Controls were suspended and subsumed within HM Treasury's approvals for such spend. In other cases, for example for test and trace contracts from August 2020 onwards, the threshold was lifted to £100m. This is explained further in Section D. All COVID-19 related cases subject to this control process that have been found on record are exhibited in the Controls Tracker and pre-CAMS (Commercial Assurance Management System) Covid Cases extract provided.[46] CAMS is the system that the Government Commercial Function uses to manage its control cases. The Cabinet Office does not hold a list of contracts which are not submitted as part of the Commercial Spend Controls.

2.29. Government policy is to adopt and encourage greater transparency in its commercial activity. During the relevant time period, central government buyers were required to publish all tender and contract documents with the contract notice, as well as details of contract awards and contracts with a value of over £10,000 on Contracts Finder. Further detail is provided in Section C from paragraph 3.19 and especially in paragraph 3.27.

[46] GRW/44 - [INQ000496916], GRW/45 - [INQ000496915]

3. SECTION C: PROCUREMENT PRINCIPLES, PROCEDURE AND POLICY

3.1. Public procurement in the UK operates under a legal framework derived from EU law and retained in domestic law following the UK's exit from the EU:

3.1.1. For procurements in England, Wales and Northern Ireland, the legal framework is set out in three sets of regulations, which apply to different types of contracts: the 2015 Regulations; the Utilities Contracts Regulations 2016; and the Concession Contracts Regulations 2016.

3.1.2. For procurements in Scotland, there are three similar sets of regulations: the Public Contracts (Scotland) Regulations 2015, the Utilities Contracts (Scotland) Regulations 2016; and the Concession Contracts (Scotland) Regulations 2016.

3.1.3. Defence and security procurements across the whole of the UK are subject to the Defence and Security Public Contracts Regulations 2011.

3.2. The Procurement Act 2023 (2023 Act), which will reform the existing procurement rules, received Royal Assent in October 2023 and secondary legislation (regulations) will be laid in 2024 to add further detail to the new regime, for example prescribing content of transparency notices. The existing legislation will apply until the new regime goes live, which is currently expected to be on Monday 28 October 2024, and will also continue to apply to procurements commenced and contracts awarded under the old rules.

3.3. In this section I address the rules which applied during the Module 5 relevant period (and which still apply). I address the changes made by the 2023 Act in Section G.

3.4. The principles of procurement which all contracting authorities must comply with when conducting procurements under the 2015 Regulations are: (a) non-discrimination, (b) transparency, (c) equal treatment, and (d) proportionality.

3.5. The 2015 Regulations set out extensive rules in relation to the design and conduct of procurement processes. For example they contain five competitive procurement options:

3.5.1. An 'open' procedure is a single-stage process in which anyone can submit a tender in response to a call for competition (Regulation 27).

3.5.2. A 'restricted' procedure (Regulation 28) which involves a 2-stage process.

At the first stage anyone can submit a request to participate in response to a call for competition. At the second stage, only those selected by the contracting authority (by reference to exclusion grounds, selection criteria and/or a minimum number of suppliers set by the contracting authority) can submit a tender.

3.5.3. A 'competitive procedure with negotiation' (Regulation 29). This procedure is a multi-stage process. At the first stage anyone can submit a request to participate in response to a call for competition. At the second stage, only those selected by the contracting authority (by reference to exclusion grounds, selection criteria and/or a minimum number of suppliers set by the contracting authority) can submit initial tenders. There is a negotiation phase where the contracting authority conducts negotiations on the basis of initial and subsequent with selected tenderers. At the final stage, final tenders are invited from the remaining tenderers.

3.5.4. A 'competitive dialogue' procedure (Regulation 30). This procedure is similar to the competitive procedure with negotiation save that the stage(s) after initial selection of tenderers are a dialogue to identify suitable solutions rather than negotiation on the basis of initial and subsequent tenders.

3.5.5. An 'innovation partnership' (Regulation 31), used for innovative products, services or works that cannot be met by what is already on the market.

3.6. The 2015 Regulations also provide for "design contests" (Regulations 78 - 82) which enable a contracting authority to acquire, mainly in the fields of town and country planning, architecture and engineering or data processing, a plan or design selected by a jury after being put out to competition. Design contests may form part of one of the five competitive procedures set out above or be 'standalone' with a prize or payment to participants.

3.7. Under the 2015 Regulations, there are required minimum periods for the competitive procurement processes referred to in paragraph 3.5:

3.7.1. In an open procedure, the minimum time period which must be allowed for the receipt of tenders after the contract notice is sent for publication is 35 days (Regulation 27(2)). This period can be reduced in certain circumstances, including to 15 days where "a state of urgency duly

substantiated by the contracting authority renders impracticable" the 35 day period (Regulation 27(5)).

3.7.2. In a restricted procedure and the competitive procedure with negotiation, the minimum time periods are:

- 30 days for receipt of requests to participate after the contract notice is sent for publication (Regulations 28(2) and 29(4)), and;
- 30 days for receipt of tenders from the date the invitation to tender is sent (Regulation 28(5) and 29(5)).

3.7.3. These time periods can be reduced in certain circumstances, including to 15 and 10 days respectively where "a state of urgency duly substantiated by the contracting authority renders impracticable" the 30 day time periods (Regulations 28(10) and 29(10)).

3.7.4. In the competitive dialogue and innovation partnership procedures, the minimum time limit for receipt of requests to participate is 30 days after the contract notice is sent for publication (Regulation 30(2) and 31(5)).

3.8. All of the procedures set out in paragraph 3.5 require contracting authorities to publish and advertise their requirements to allow all tenderers to submit a request to participate (or tender) if they wish. The contracting authority is also required to publish any selection criteria it will use to select those who submit a request to participate and the criteria and the scoring mechanism it will use to evaluate tenders. The minimum time periods are intended to allow sufficient time for clarification questions before responses or tenders are due and must be extended to allow tenderers sufficient time after responses are provided.

3.9. Regulation 87 requires a 10 day standstill period at the end of any procedure, preventing a contract being entered until the end of the 10th day after a notice has been sent under Regulation 86 to all relevant tenderers. Therefore, the absolute minimum time period from publication of a contract notice to award of contracts is 25 days, using an open procedure and relying on reduced timescales for urgency.

3.10. However, these mandatory minimum periods do not include the necessary time from a practical/operational perspective, which is also required when carrying out a competitive procurement under any of the procedures set out above, to:

3.10.1. Prepare and publish an invitation to tender or request to participate;

3.10.2. Allow tenderers to submit, and the contracting authority to respond to, clarification questions;

3.10.3. Evaluate tenders and/or requests to participate;

3.10.4. In the case of the competitive dialogue procedure and the competitive procedure with the negotiation, organise, prepare and conduct negotiation/dialogue;

3.10.5. Send a notice of a decision to award a contract to each tenderer containing the information required by Regulation 86 (including the reasons for the decision and the characteristics and relative advantages of the successful tender and the score obtained by (i) each recipient and (ii) the successful tenderer);

3.11. Under the 2015 Regulations, contracting authorities can also award framework agreements (Regulation 33):

3.11.1. Framework agreements are defined in Regulation 33(2) as "an agreement between one or more contracting authorities and one or more economic operators, the purpose of which is to establish the terms governing contracts to be awarded during a given period, in particular with regard to price and, where appropriate, the quantity envisaged".

3.11.2. The framework agreement itself must be awarded in accordance with the 2015 Regulations (i.e. one of the competitive procurement process set out above, or, by direct award if relevant conditions are satisfied under Regulation 32))

3.11.3. Once a framework agreement has been awarded, then if a contracting authority which is listed as a party that can utilise the framework agreement wishes to enter a contract with a supplier which is a party to the framework agreement it can do so under Regulation 33, so long as the contract to be awarded is within the term (maximum 4 years unless there are exceptional circumstances), maximum value, and scope of the framework agreement. Contracts issued under framework agreements are often called "call-off contracts".

3.11.4. The terms and conditions for any call-off contract will usually be set out in the framework agreement. For single-supplier framework agreements,

call-off contracts are awarded within the limits set out in the framework agreement. For multi-supplier framework agreements, call-off contracts are awarded either with or without re-opening competition between the suppliers who are party to the framework agreement. A re-opening of competition is known as a mini-competition and can be undertaken under Regulation 33(8)(c) where not all the terms and conditions for the provision of the goods or services are set out in the framework agreement. An award without a mini competition is allowed under Regulation 33(8)(a) if the procurement documents for the framework set out objective conditions upon which call-off contracts will be awarded and the framework agreement sets out the terms and conditions for any call-off contract). Awards under a framework agreement without further competition are often referred to as 'direct awards under a framework' and are permitted where an award can be justified against the objective criteria established by the framework terms, as is often the case when purchasing from a catalogue of standard goods or services. This is not to be confused with the award of contracts without a competition under Regulation 32, on which there is further detail below.

3.12. The 2015 Regulations also allow for the award of contracts under a dynamic purchasing system (Regulation 34):

3.12.1. Regulation 34(1) says: "Contracting authorities may use a dynamic purchasing system for commonly used purchases the characteristics of which, as generally available on the market, meet their requirements."

3.12.2. A dynamic purchasing system is a list of suppliers who have been admitted to the system following a selection process.

3.12.3. Dynamic purchasing systems can only be used for commonly used purchases generally available in the market. In order to award a contract under a dynamic purchasing system, the restricted procedure must be used.

3.13. Some of the procurement carried out for the pandemic was carried out through the use of existing framework agreements and dynamic purchasing systems, where there was an existing framework agreement or dynamic purchasing system which covered the relevant supply.

Direct Awards

3.14. The 2015 Regulations also contain an ability to award contracts without following one of the competitive procedures under Regulation 32 (known as the negotiated procedure without prior publication) in a range of specified circumstances. This is often referred to as 'direct award' and was invoked for procurement carried out during the pandemic where urgent requirements needed to be satisfied. In particular, contracting authorities often relied on Regulation 32(2)(c) which states that a negotiated procedure without prior publication is permitted: "insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with."

3.15. The normal competitive procurement processes embody the principles of fair, open and transparent procurement, thereby mitigating to the fullest extent possible the risk of corruption, but by their nature are time intensive; the statutory required periods for a competitive procurement using one of the procedures set out at paragraph 3.5 above are as an absolute minimum 25 days (taking into account the time which must be allowed for receipt of tenders when relying on reduced time periods in a state of urgency and the mandatory standstill period as referred to above). This period does not include time to prepare the tender or review bids. Competitive procurement processes typically take substantially longer than these statutory minimum periods; large-scale procurements may run for months or even years in complex cases.

3.16. The government made use of pre-existing flexibility in the procurement regulations to procure goods and services at speed, and these were very necessary, because of the urgency brought about by the pandemic. To seek to ensure that offers to accept or reject offers for certain goods (such as PPE) in hours or days it was not possible to run a procurement under a competitive process, even by taking advantage of the reduced minimum time periods allowed under the 2015 Regulations. The public interest was best served by being able to act quickly and decisively, relying on existing mechanisms in the regulations, to secure necessary goods and services.

3.17. There is always a need to ensure value for taxpayers' money even in the midst of an emergency. But with global demand at unheard of levels, and much manufacturing capacity for key products closed due to COVID-19, our risk appetite had to change. The risks that contracts might not perform needed to be balanced against the risk to the NHS and the public if we failed to secure items, such as PPE, which the health service so desperately needed. We put in processes to try to ensure we paid the

market price at the time, e.g. when there was a global shortage of PPE and countries were competing for the same product, but that meant we had to persistently operate using Regulation 32(2)(c) instead of the normal competitive procedures.

3.18. Regulation 32(2)(c) allows contracts to be awarded and entered into more quickly than the mandatory minimum periods for competitive procurements and is less burdensome and time-consuming in practical and operational terms. I explain the policy guidance issued in respect of Regulation 32(2)(c) and the use of direct awards generally in the relevant period below.

3.19. As part of its transparency obligations, the 2015 Regulations require the contracting authority (i.e. the government department entering into the contract) to publish the details of those contracts. There are two different types of notices.

3.20. First, Regulation 50 requires contracting authorities to publish contract award notices ("CANs") within 30 days of the award of any above threshold contracts including those directly awarded under regulation 32(2)(c) but excluding call-off contracts awarded via frameworks. Up until 31 December 2020, the end of the Brexit transition period, these CANs were to be issued in the Official Journal of the European Union and its Tenders Electronic Daily (TED) system. Since 31 December 2020, Regulation 51 has been amended to require CANs to be published on the Find a Tender Service platform ("Find a Tender" is the "UK e-notification service for publication" referred to in Regulation 51.)

3.21. If Regulation 32(2)(c) is relied on (e.g. for an award without competition), the CAN must additionally describe the justification for using Regulation 32(2)(c), and in particular explain the extreme urgency which led to the need for an award on these grounds. The CAN must be individually drafted for each contract award. In practice, this part of the CAN will often be drafted based on the Regulation 84 report which a contracting authority is required to produce for each above-threshold contract and which must include "for negotiated procedures without prior publication, the circumstances referred to in regulation 32 which justify the use of this procedure".

3.22. Second, there are separate requirements in:

3.22.1. Regulation 108 for information about awarded contracts (as a minimum, the name of the contractor, the date the contract was entered and the value) to be published on the Contracts Finder platform (a Contracts Finder Notice (CFN)) where a contract award notice has been published on the

Find a Tender Service platform (or before 31 December 2020, TED[47]) or where a call-off contract is awarded via a framework; and

3.22.2. Regulation 112 which requires similar information to be published on Contracts Finder for central government contracts above £10,000 ex VAT (£25,000 for sub-central authorities including NHS Trusts)

3.23. Regulations 108 and 112 only state that the CFNs have to be published within a reasonable time.

3.24. However, Regulations 108(6) and 113(3) require contracting authorities, when complying with those Regulations, to have regard to guidance by the Minister for the Cabinet Office on issuing CFNs. During the relevant period this guidance included (i) the "Publication of Central Government Tenders and Contracts" updated in November 2017 ("the Transparency Guidance"),[48] and (ii) PPN 07/16.[49]

3.25. The Transparency Guidance expanded on the requirements of the 2015 Regulations and includes policy guidance that requires central government departments to publish the actual contract documents with the CFN, and that CFNs be published within 20 days of the award of the contract, or the end of the standstill when applicable.

3.26. This latter timescale would need to be read with section 108(5) of the 2015 Regulations which prohibited the publication of CFNs before a CAN was to be issued (where it was required to be). The time-limit for CANs was 30 days. Earlier guidance had recommended that CFNs be published within 90 days after the contract award date.[50]

3.27. The Transparency Guidance and PPN 07/16 were both withdrawn in June 2021. Subsequent guidance was provided by PPN 09/21[51] and PPN 01/23.[52] Under PPN 09/21 "a reasonable time" for the publication of CFNs means 30 days after contract award for central contracting authorities and 90 days after contract award for sub-central contracting authorities.

3.28. As stated in the Executive Summary, I believe that if contracting departments had published contract details (CANs and CFNs) for ventilators, PPE and test and trace

[47] Tenders Electronic Daily, an e-publishing platform that is a supplement to the Official Journal of the EU.
[48] GRW/46 - [INQ000477302]
[49] GRW/47 - [INQ000477961]
[50] GRW/47 - [INQ000477961]
[51] GRW/48 - [INQ000477289]
[52] GRW/49 - [INQ000477960]

(and other COVID-19 contracts) in a more timely manner this would have helped maintain public trust in the procurement system. The delays did not flow from a desire to avoid transparency.

3.29. In the case of the Ventilator Challenge, there were initial CANs and CFNs published in May, August and December 2020. However, by oversight (a) copies of the contracts themselves were not included with the CFNs, and (b) there was a delay in issuing subsequent CANs confirming the actual spend and the formal contracts entered for the supply of ventilators. This oversight was regrettable, but not deliberate. The contracting team had been moved on to other urgent tasks in the summer of 2020. In the case of the contracts entered into by the Cabinet Office, following an internal review these oversights were corrected in February 2023. Further details of the action taken to rectify the oversight are in paragraph 4.120.

3.30. In the case of PPE, the delay in the issuing of CANs and CFNs simply reflected the volume of work required compared to the resource carrying it out. The relatively small DHSC commercial team had to draft and publish 394 CANs for the Parallel Supply Chain and the 'Make' activity alone. The publication of a CAN (and CFN) requires significant commercial and legal review. The publishing team carrying out this task for the PPE contracts was not directly involved in the original procurement, making the collection and collation of the required information even more time consuming and complicated. CANs cannot be changed once issued (albeit it is possible to issue a new, replacement CAN). There was particular thoroughness and scrutiny for these contracts given (a) the added requirement of having to include the justification for the direct award and (b) the risk of legal challenge (which was accentuated given the challenges and ensuing controversy which had already emerged in respect of these procurements). In the interests of transparency, and while not legally required, Regulation 84 reports were also generally published with CFNs, which would have added to the time required to publish the CANs and CFNs.

3.31. To illustrate the publication requirements in force at the time, the table below shows award notice publication obligations as they stood between 1 January 2020 and 24 June 2021 for contracts for supplies and services[53] procured by contracting authorities. These will be simplified when the Procurement Act 2023 comes into force.

[53] Contracts for 'light touch services' as set in Schedule 3 of the 2015 Regulations were subject to a higher threshold for CAN publication of £663,540

Scenario	CAN required?	CFN required?
Direct awards made in reliance of regulation 32 made by a central contracting authority	Yes, if valued above £122,976. The 2015 Regulations require CANs to be published no later than 30 days after contract award.	Yes, if valued above £10,000. The 2015 Regulations require publication of CFNs within a reasonable time. The Transparency Guidance advised central contracting authorities to publish CFNs within 20 days of award.
Direct awards made in reliance of regulation 32 made by sub-central contracting authority	Yes, if valued above £189,330. The 2015 Regulations require CANs to be published no later than 30 days after contract award.	Yes, if valued above £25,000. The 2015 Regulations require publication of CFNs within a reasonable time.
Contracts awarded pursuant to one of the competitive procedures set out in the 2015 Regulations by a central contracting authority	Yes, if valued above £122,976. The 2015 Regulations require CANs to be published no later than 30 days after contract award.	Yes, if valued above £10,000. The 2015 Regulations require publication of CFNs within a reasonable time. The Transparency Guidance advised central contracting authorities to publish CFNs within 20 days of award.
Contracts awarded pursuant to one of the competitive procedures set out in the 2015 Regulations by a sub-central contracting authority	Yes, if valued above £189,330. The 2015 Regulations require CANs to be published no later than 30 days after contract award.	Yes, if valued above £25,000. The 2015 Regulations require publication of CFNs within a reasonable time.
Call-off contracts let via framework by a central contracting authority	No, irrespective of value	Yes, if valued at above £10,000. The 2015 Regulations require publication of CFNs within a reasonable time. The Transparency Guidance advised central contracting authorities to publish CFNs within 20 days of award.
Call-off contracts let via framework by a sub-central contracting authority	No, irrespective of value	Yes, if valued above £25,000. The 2015 Regulations require publication of CFNs within a reasonable time.

3.32. A further complication was that because of the limitations in the IT systems used by SCCL and DHSC at the time, the details for contracts and the process steps were in many cases spread across multiple systems in different departments, only accessible by their departmental users. Consequently, not all the information needed by the publishing team was quickly or readily available in the normal way. Overall, while the publication of CANs and CFNs for PPE started in late June 2020, most of the required notices were published after the statutory deadline of 30 days for CANs and the 20 days for CFNs (as per the Transparency Guidance). This delay in transparency is regrettable. Publishing more limited key information sooner (such as the identities of the contracting parties and values) would also have attracted criticism regarding a lack of transparency and the resultant concerns. However, these delays arose for understandable reasons and were yet another consequence of the special circumstances brought about by the pandemic and the extraordinary pressure on all commercial staff. Similar delays arose in the publication of CANs and CFNs for Test and Trace contracts.

3.33. It may be asked whether the GCF could have offered extra resources to DHSC for the publication activity for PPE. However, at the time considerable effort was going into other COVID-19 related procurement. In addition, almost all the 500 people who at peak had been working on PPE buying within the Parallel Supply Chain had gone back to their original departments.

3.34. Publication requirements within the 2023 Act have built in the learnings from this phase. In particular, a transparency notice will be required to be issued *before* any direct award is made, and the previous obligation to separately publish the justification for each direct award has been removed in cases where a Minister has made regulations allowing for the direct award of contracts in order to protect human, animal or plant life or health or public order or safety. I expand on these in Section G below.

The Cabinet Office role

Pre-pandemic

3.35. Before the pandemic, procurement by a government department was generally carried out by its own commercial team who would be responsible for the award. Management of the contract would be the responsibility of whoever was the contract owner in that department (often a policy or finance or HR or operations colleague). The same was the case for each ALB and NHS Trust (albeit NHS Trusts could also use the central NHS Supply Chain system which I explain below).

3.36. Other contracting authorities such as local authorities were responsible for their own procurements and would have their own arrangements for undertaking procurements, also regulated by the 2015 Regulations.

3.37. Pre-pandemic the Cabinet Office's function and role in relation to operational procurement was three-fold (outside of its responsibility for procurement policy across Government, and of counter-fraud work which is described in Section E below):

3.37.1. Carrying out those procurements required by the Cabinet Office officials and ministers, through a local commercial team reporting to the Cabinet Office Chief Operating Officer;

3.37.2. Carrying out the wider functions undertaken by Central Commercial Teams (CCTs) based in the Cabinet Office on behalf of OGDs; and,

3.37.3. Procurement of frameworks for 'common goods and services' for OGDs carried out via the CCS (outlined in Sections A and B).

3.38. It should be noted that the Cabinet Office did not, during the relevant period, have a regulatory or 'policing' role in respect to compliance with the relevant procurement regulations and guidance. Individual contracting authorities were, and continue to be, responsible for the conduct of their own procurement process and for ensuring such processes are compliant with procurement law and policy. As described in paragraph 3.80 below, the Cabinet Office did invite parties concerned about possible breaches of regulations (or other matters related to public contracts) to apply to the Public Procurement Review Service (PPRS) which would then investigate and publish findings on gov.uk.[54]

3.38.1. PPRS sits within the Cabinet Office and operates within its scope and remit.[55]

3.38.2. The findings of PPRS consist of best practice advice, and would not include formal findings that legal obligations had been breached.

3.38.3. PPRS does not have any records of complaints directly relating to COVID-19 related procurement, for example relating to PPE or testing kits.

[54] GRW/50 - [INQ000496914]
[55] GRW/51 - [INQ000496760]

3.39. The Cabinet Office, working with the Government Legal Department, develops and maintains a set of 'model contracts' which embody commercial best practice and reflect current legislation and case law.[56] These template contracts are publicly available for contracting authorities to use. While the model contracts represent best practice, many external legal firms offer similar templates. It is up to the individual contracting authority to choose a contracting model that suits its particular purpose and any of these templates will need customising to fit individual circumstances, so it should not be expected that the more complex contracts will be identical across different entities. The Cabinet Office has an expectation that contracting authorities will make appropriate choices of contracting model (and if an award meets the threshold for the spend controls process, the contracting model chosen may be the subject of discussion). Since August 2023, PPN 08/23 has mandated the use of the model contracts for central government for the purchase of bespoke goods or services which are not bought via an existing framework or dynamic purchasing system. The Cabinet Office did not however specify standard terms that needed to be used by Departments during COVID-19. Guidance documents did make recommendations about, for example, length of term, that would be appropriate for a rapidly changing emergency situation and individual departments were free to develop their own template contract documents and encourage use by their staff (as DHSC did as described in paragraphs 4.204 and 4.450).

During the pandemic

3.40. During the pandemic commercial staff in the Cabinet Office continued to provide many of the same functions set out above in respect of procurement. However, overall, staff based in the Cabinet Office (primarily in the CCTs) played a much more significant and prominent role in direct support of procurements within OGDs during the relevant period.

3.41. The Cabinet Office continued to develop and publish policy in relation to procurement. On 18 March 2020, the Cabinet Office issued PPN 01/20[57] which recognised that, given the exceptional circumstances caused by the pandemic, authorities may need to procure goods, services and works with extreme urgency and that authorities were permitted to do so under the following grounds:

3.41.1. Direct award due to extreme urgency (Regulation 32(2)(c)).

[56] GRW/52 - [INQ000496683] is an example of the version in place in 2020.
[57] GRW/26 - [INQ000048822]

3.41.2. Direct award due to absence of competition or protection of exclusive rights (under Regulation 32(2)(b)).

3.41.3. Call off from an existing framework agreement (either by a direct award where provided for in the specific framework agreement or via a mini-competition) or dynamic purchasing system.

3.41.4. Call for competition using a standard procedure with accelerated timescales, as permitted if a state of urgency rendered the standard timescales impracticable (Regulations 27(5), 28(10) and 29(10)).

3.41.5. Extending or modifying a contract during its term (under Regulation 72(1)).

3.42. Under the direct award processes provided for in Regulation 32, the procurement does not need to be advertised, there does not need to be a formal competitive process and the minimum periods do not need to be observed. PPN 01/20 explained that contracting authorities needed to take steps to clearly document any use of the above grounds for a direct award: "You should ensure you keep proper records of decisions and actions on individual contracts, as this could mitigate against the risk of a successful legal challenge. If you make a direct award, you should publish a contract award notice (CAN - Regulation 50) within 30 days of awarding the contract."[58]

3.43. PPN 01/20 then provided further guidance on each of the above options. On Regulation 32(2)(c), PPN 01/20 explained that it could only be used if the four tests below were met.

3.44. Regulation 32(2)(c) sets out circumstances when a direct award is permitted. The 4 tests or criteria, as explained in PPN 01/20 (with examples of how they may be met in the circumstances of the pandemic), are:

3.44.1. "There are genuine reasons for extreme urgency, eg:

- you need to respond to the COVID-19 consequences immediately because of public health risks, loss of existing provision at short notice, etc;
- you are reacting to a current situation that is a genuine emergency - not planning for one.

[58] GRW/26 - [INQ000048822]

3.44.2. The events that have led to the need for extreme urgency were unforeseeable, eg:

- the COVID-19 situation is so novel that the consequences are not something you should have predicted.

3.44.3. It is impossible to comply with the usual timescales in the 2015 Regulations, eg:

- there is no time to run an accelerated procurement under the open or restricted procedures or competitive procedures with negotiation;
- there is no time to place a call off contract under an existing commercial agreement such as a framework or dynamic purchasing system.

3.44.4. The situation is not attributable to the contracting authority, eg:

- you have not done anything to cause or contribute to the need for extreme urgency."

3.45. During the pandemic, dynamic purchasing systems were often used as means of identifying potentially suitable suppliers. Regulation 34(5) of the 2015 Regulations requires a restricted procedure for the award of contracts under a dynamic purchasing system, meaning that this was not a suitable route for urgent awards. However, as dynamic purchasing systems are essentially lists of suppliers who have been assessed as capable of providing certain types of services, they were a useful way of quickly identifying suppliers who were capable of delivering particular requirements. Once suppliers were identified, awards were made under regulation 32(2)(c) and not under the dynamic purchasing system.

3.46. PPN 01/20 explained that contracting authorities should keep a written justification that such an award satisfies the direct award tests and ensure that steps are taken to ensure they are still met under any future procurement.[59]

3.47. PPN 01/20 also explained that "It is important that contracting authorities continue to achieve value for money and use good commercial judgement during any direct award." and continued by discussing abnormally high pricing and mechanisms to secure price reductions through the life of a contract.[60]

[59] GRW/26 - [INQ000048822]
[60] GRW/26 - [INQ000048822]

3.48. PPN 01/20 was subsequently updated by the Cabinet Office in PPN 01/21 issued on 4 February 2021.[61] The main change in PPN 01/21 was a more detailed section on value for money which contained the guidance for contracting authorities to "continue to achieve value for money and use good commercial judgement and sound decision-making in an emergency". The PPN outlined commercial risks in undertaking procurements in an emergency and detailed steps that should be taken to mitigate these, for example: keeping a record of decisions, considering some form of advertisement, running an informal competition and/or undertaking due diligence on the supplier market before making a direct award.

3.49. Both PPN 01/20 and PPN 01/21 advised contracting authorities that contract award notices should be published following a direct award. PPN 01/21 reminded authorities that publication of contract award notices may be required in other circumstances and of where to publish such notices and pointed to further guidance in PPN 08/20.[62]

3.50. Other internal practical guides and legal notes were circulated to CFLG first on 18 March 2020 with a further update on 20 March 2020,[63] including Legal Notes on Direct Award,[64] Legal Notes on Urgent Procurement[65] and Commercial guidance on the use of direct award for extreme urgency.[66]

3.51. The decision to rely on Regulation 32.2.c is the responsibility of individual contracting authorities, which must make that decision in the context of each individual procurement. The justification for the decision must be recorded (and subsequently included in the published CAN) and meet the four criteria set out in paragraph 3.44 above. The need for urgent procurement existed frequently throughout the pandemic, as new variants of concern emerged and new technologies or therapies became available to combat the disease. Individual contracting authorities issued guidance to their procurement teams reminding them of their responsibilities under the regulations.[67] There was no 'blanket announcement' by the Cabinet Office that it was no longer appropriate to use Regulation 32.2.c, not least because that decision always needs to be considered in the context and circumstances of the specific procurement in question. If the Cabinet Office had definitively opined on this issue it would likely have limited contracting authorities' discretion and represented deviation from the

[61] GRW/39 - [INQ000471043]
[62] GRW/39 - [INQ000372699]
[63] GRW/55 - [INQ000496696]
[64] GRW/56 - [CAB026213914]
[65] GRW/57 - [CAB026213917]
[66] GRW/58 - [INQ000496695]
[67] For example [GRW/59 - GWI_INQ000496703]

general and long-established principle that contracting authorities are responsible for their own procurement decisions. In any event, the Cabinet Office does not have legal powers which could have been used to prohibit a contracting authority from relying on regulation 32(2)(c).

Government procurement and management of outside interests

3.52. In practice, decisions about government procurement are often made by civil servants, exercising functions on behalf of a Minister. The vast majority are made by Senior Civil Servants in commercial roles. Ministers are rarely directly involved in the day-to-day running of a procurement but, for complex or high profile procurements, will be briefed and may approve the final decision on contract award, on advice and recommendations from civil servants. The management of outside interests (for example family and social connections, financial interests, etc) in relation to people making those decisions has evolved since 2010, and also since the end of the pandemic.

3.53. There are overarching codes of conduct setting expectations about the management of outside interests in the form of the Ministerial and Civil Service Codes and these apply to all Ministers and civil servants respectively. There are also legal requirements (principally the 2015 Regulations) and pieces of guidance that apply specifically to procurements.

3.54. As outlined in Section B of this statement, civil servants conduct different roles in procurement across a range of different functions, departments and organisations. This part of the statement seeks to explain how the management of civil servants' outside interests is dealt with across these, with particular focus on those civil servants making decisions on procurement.

3.55. After the pandemic the government identified areas of potential improvement and so issued new pieces of guidance to Ministers and civil servants to help them manage their outside interests. Some guidance applies to the management of interests more generally, for all, and some applies to the specific context of government procurement. This guidance is explained further in this section.

3.56. The management of outside interests is dealt with across a number of different policies and how it is handled differs depending on what an individual's work may involve (e.g. if an individual is working on a procurement). Individual departments were responsible for implementing local policies and procedures for managing conflict of interests in line

with the Code(s) and Regulations for procurement covered below.

Overarching codes of conduct

3.57. The UK public sector takes a principles-based approach to addressing conflicts of interest. All Ministers and civil servants have duties in relation to the management of their outside interests under the Ministerial and Civil Service Codes. These apply equally to those making procurement decisions and those not. These have been in place since 2010.

Ministers

3.58. All Ministers (both MPs and Peers) are subject to the Ministerial Code. The Ministerial Code sets out the standards of conduct expected of ministers. The Code makes clear that Ministers are expected to conduct themselves in a way that upholds the highest standards of propriety, and provides guidance on how they should act and arrange their affairs in order to ensure this. This includes a duty to ensure that no conflict arises, or appears to arise, between their public duties and their private interests. Ministers who are members of the House of Lords are also subject to the Code of Conduct for Members of the House of Lords. As described in the Code: "The operation of the Code is overseen by the House of Lords Conduct Committee".[68] Ministers who are Members of the House of Commons are also subject to the Code of Conduct for Members of Parliament.

3.59. The Ministerial Code explains that: "it is the personal responsibility of each Minister to decide whether and what action is needed to avoid a conflict or the perception of a conflict, taking account of advice received from their Permanent Secretary and the Independent Adviser on Ministers' interests."

3.60. Section 7 of the Ministerial Code outlines the requirements and process by which ministers' outside interests are declared and managed. The key sections are as follows:

3.60.1. "7.3 On appointment to each new office, Ministers must provide their Permanent Secretary with a full list in writing of all interests which might be thought to give rise to a conflict. The list should also cover interests of the Minister's spouse or partner and close family which might be thought to give rise to a conflict."

[68] GRW/60 - [INQ000496742]

3.60.2. "7.4 Where appropriate, the Minister will meet the Permanent Secretary and the Independent Adviser on Ministers' interests to agree action on the handling of interests. Ministers must record in writing what action has been taken, and provide the Permanent Secretary and the Independent Adviser on Ministers' interests with a copy of that record."

3.61. The requirement to complete a declaration of all interests which might give rise to a conflict also applies whenever there is a substantial change to a Minister's portfolio and a Minister is expected to inform their department of any substantive change in their circumstances during the intervening period.

3.62. As set out in their terms of reference, one role of the Independent Adviser on Ministers' Interests is to "review any information provided by a Minister and may, in confidence, provide advice to that Minister on any action that should be taken by the Minister in order to uphold the standards set out in the Ministerial Code (7.4)."[69]

3.63. The terms of reference for the Independent Adviser set out that they are responsible for publishing a statement covering the relevant interests of ministers at least twice yearly, known as the List of Ministers' Interests. As set out in the introduction section of the December 2023 List of Ministers' Interests, "a role of the Independent Adviser is to advise on what it is necessary to publish within the list. The list is not a register of interests and does not therefore include every interest that a minister has declared in relation to themselves and their family members."[70]

3.64. The List of Ministers' Interests should be read alongside the relevant Parliamentary register of interests (i.e. the House of Commons Register of Members' Financial Interests and the House of Lords Register of Members' Interests), as well as relevant information published by the Electoral Commission.

3.65. In 2022 the Cabinet Office issued guidance[71] to departments which set out the basic principles about how to involve ministers during each key stage of the procurement process. The document covers the declaration of personal and professional interests and procedures that should be put in place to manage any conflicts. The principles go on to cover ministerial involvement outside of, and during a formal procurement process; and ministerial involvement in contract and supplier management.

Civil Servants

[69] GRW/61 - [INQ000471058]
[70] GRW/62 - [INQ000471057]
[71] GRW/63 - [INQ000471040]

3.66. The management of conflicts of interest for civil servants is addressed in various different documents, the starting point of which is the Civil Service Code[72] (last updated on 16 March 2015) and explained in this section. According to the Code all civil servants are expected to comply with the four core values of:

3.66.1. Integrity: "You must not misuse your official position, for example by using information acquired in the course of your official duties, to further your private interests or those of others";

3.66.2. Honesty: "You must not be influenced by improper pressures from others or the prospect of personal gain";

3.66.3. Objectivity: "You must take decisions on the merits of the case"; and

3.66.4. Impartiality: "You must not act in a way that unjustifiably favours or discriminates against particular individuals or interests."

3.67. In addition, the Civil Service Management Code, published by the Cabinet Office, outlines civil servants' terms and conditions of service for government departments and agencies. The Management Code sets out more detailed principles and rules for departments and civil servants. The latest version of the Code was published in November 2016.[73]

3.68. One of the core principles for civil servants set out at paragraph 4.1.3c of the Civil Service Management Code is the obligation to declare any conflicts of interest. It sets out that where a conflict arises how this should be declared so that senior management can determine how best to proceed.

3.69. This general rule has applied to any procurement related activities conducted by civil servants prior to, during, or since the pandemic.

3.70. Paragraph 4.3.1 of Civil Service Management Code further sets out the following rule for the standards of propriety:

3.70.1. "Departments and agencies must not, unless the civil servant has fully disclosed the measure of his/her interest in the contract and senior management has given permission, let contracts to:

a. any civil servant in the department or agency;

[72] GRW/64 - [INQ000357907]
[73] GRW/65 - [INQ000471036]

b. any partnership of which a civil servant in the department or agency is a member; or

c. any company where a civil servant in the department or agency is a director (except as a nominee of the department or agency).

3.71. To enforce this rule, departments and agencies must require their staff to report relevant business interests. Paragraphs 4.3.8 to 4.3.9 of the Civil Service Management Code provide the standards for these and that they should be reflected in staff handbooks.

2015 Regulations

3.72. One of the specific obligations contained in the 2015 Regulations, in particular Regulation 24, is for contracting authorities to take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement procedures, so as to avoid any distortion of competition and to ensure equal treatment of all bidders and suppliers.

3.73. A conflict of interest is defined in Regulation 24(2) as "any situation where relevant staff members have, directly or indirectly, a financial, economic or other personal interest which might be perceived to compromise their impartiality and independence in the context of the procurement procedure." The "relevant staff members" are staff of the contracting authority (or a procurement service provider acting on its behalf) "who are involved in the conduct of the procurement or may influence the outcome."

3.74. If a conflict of interest cannot be effectively remedied, the contracting authority has a discretion to exclude the tenderer from the procurement.

3.75. Further, Regulation 41 sets out that where a tenderer has acted in an advisory capacity to the contracting authority or has otherwise been involved in the preparation of the procurement, the contracting authority must take appropriate measures to ensure that competition is not distorted by the participation of that tenderer in the procurement.

3.76. In addition, Regulation 84 requires that measures taken to remedy any conflicts of interest identified by the contracting authority should be documented in writing and included in the procurement report i.e. a written report for every contract award (save a call off contract awarded under an existing framework agreement), framework

agreement, or establishment of a dynamic purchasing system.

3.77. Any conflicts identified should be recorded throughout the procurement process and a Regulation 84 report should be produced for procurements to which that requirement applies. Records should include the nature of the conflict and action taken.

Guidance during the relevant period

3.78. For civil servants directly involved in a procurement, they are required to sign a conflict of interests declaration at the start of the procurement as well as declaring any new conflicts or potential conflicts that arise during the procurement (e.g. once it becomes clear which suppliers are bidding). The procurement team will review the declarations and where a conflict or potential conflict is identified, consider whether any mitigations are required. Mitigations might include requiring certain individuals not to be involved in the procurement either at all or in regard to certain decisions or roles and seeking assurances that matters relating to the procurement will not be discussed outside of a predetermined group of staff and/or stakeholders.

3.79. The general government policy guidance on managing conflicts of interest at the time the pandemic started was set out at paragraphs 22 to 27 of the guidance accompanying the Cabinet Office's PPN 01/19, 'Applying Exclusions in Public Procurement, Managing Conflicts of Interest and Whistleblowing' (22 February 2019).[74] This guidance summarised the relevant provisions in the 2015 Regulations and advised in-scope organisations to refer to their own internal guidance and/or procedures on identifying, reporting and managing conflicts of interest, as well as the National Audit Office report 'Conflicts of Interest'

3.80. During the relevant period it was the responsibility of in-scope organisations (as defined in PPN 01/19) to check that these policies and procedures were enabling the organisation to comply with its legal obligations regarding conflicts of interest. The Cabinet Office did not have a policing function (for example, investigating whether in-scope organisations had made and retained appropriate records of conflicts and mitigations) although it would have been possible for concerned individuals to report potential breaches to the PPRS (see paragraph 3.38), which is run by the Central Commercial Teams in the GCF. During the relevant period, no complaints were raised with the PPRS regarding conflicts of interest in the purchase of medical supplies.[75]

3.81. Following the 'Boardman Review of Government Procurement in the COVID-19

[74] GRW/66 - [INQ000101269]
[75] GRW/50 - [INQ000496914]

pandemic' and the National Audit Office (NAO) report 'Investigation into government procurement during the COVID-19 pandemic' (November 2020),[76] which recommended that additional, practical guidance be made available for all central government contracting authorities regarding the management of conflicts of interest in commercial environments, PPN 01/19 was replaced by PPN 04/21[77] and updated guidance on 20 May 2021 (produced by the Cabinet Office) which dealt with conflicts of interests in Section 2 of the guidance.

3.82. PPN 04/21 built on the previous policy, with more detailed guidance to assist contracting authorities to develop and enhance local strategies, systems, processes and procedures to prevent, identify and remedy conflicts of interest. The updated policy requires central government contracting authorities to have an internal framework in place to identify, prevent and manage conflicts of interests. An effective framework was described as including guidance and training; declarations of interests; conflict identification and resolution; audit and sanctions; and supply-side requirements. A template conflict of interest declaration form was also published with PPN 04/21.

3.83. Most of the senior commercial staff engaged in procurement during the pandemic were employed by the GCO. The GCO has its own Conflict of Interest Policy.[78] As part of their employment contract, given their likely involvement in procurements, all GCO staff are required every year to complete a conflicts of interest declaration form.

3.84. For GCO staff, when candidates accept an offer of employment with the GCO (including internal staff taking up new roles within the GCO, including short term deployments), they are asked to complete a questionnaire which asks them to confirm any potential political/financial conflicts of interest.[79] If the employee declares a potential conflict, it is sent to the employee's line manager to complete a local risk assessment and returned to GCO HR to store on the employee's central file.

3.85. Under Cabinet Office Declaration of Interest Policy more generally, Cabinet Office Business Unit Heads are responsible for keeping declaration of interest records at a local level and providing quarterly assurance that these records are up to date. There were no material differences during the pandemic as to how declarations needed to be made or how quickly they needed to be recorded.

[76] GRW/67 - [INQ000234626]
[77] GRW/68 - [INQ000092628]
[78] GRW/12 - [INQ000480604]
[79] GRW/69 - [INQ000477278]

3.86. In addition, since the financial year 2022/23 Cabinet Office has published details (names, post and outside employment), on an annual basis, of all SCS who hold outside employment which is paid or otherwise remunerated (and has been approved in line with the requirements of 4.3.4 of the Civil Service Management Code).

3.87. Further details on changes made since the pandemic are outlined below.

Changes since the pandemic

3.88. New pieces of guidance were published about the way that outside interests should be managed by ministers and civil servants after the pandemic, reflecting the fact that potential improvements were found to how such guidance should be communicated. Largely this guidance was already extant, albeit benefitted from being updated, standardised, and centralised.

3.89. The first of these was in June 2022 when the Cabinet Office published guidance 'Declaration and management of outside interests in the Civil Service'. This guidance was subsequently updated on 25 April 2023.[80] This document, which applies to all civil servants, is intended to provide:

3.89.1. "a consistent approach to understanding relevant outside interests and what might present a conflict";

3.89.2. "guidance intended to support departments with the development of their own policies";

3.89.3. "a minimum set of information that must be captured when members of the Senior Civil Service (SCS) declare relevant outside interests";

3.89.4. "the points at which a declaration is required, including prior to appointment to the Civil Service, when moving to a new role, and on an annual basis".

3.90. This document provides guidance for civil servants on how to consider any 'relevant' outside interests and outlines that it is the responsibility of individual civil servants to declare actual potential or perceived conflict of interest as follows:

3.90.1. "Actual conflicts - where there is a risk that an official's ability to apply judgement is or could be impaired or influenced by an extant secondary interest."

3.90.2. "Potential conflicts - where an official's ability to apply judgement or act in

[80] GRW/70 - [INQ000471051]

their role could be impaired or influenced by a secondary interest in the future."

3.90.3. "Perceived conflicts - where an official's ability to apply judgement or act in one role could reasonably be perceived as impaired or influenced by a secondary interest (i.e it could cause a reasonable person to think there was a conflict of interest)"

3.91. The guidance goes on to explain how individuals should declare these interests; the process for doing so; resolving conflicts of interest; roles and responsibilities; and guidance for the publication of detail on the SCS secondary paid employment.

3.92. On 27 July 2022, the Cabinet Office published specific guidance on 'Principles for Ministerial involvement in commercial activity and the contracting process'.[81] This guidance offers advice on how to maximise the value of Ministerial involvement in Government commercial activity while maintaining the necessary safeguards. This guidance was published partly as a result of Boardman 2 (discussed later in the statement in Section F), and partly because I recognised that pre-existing guidance did not cover Ministerial involvement in procurements, including pre-award or contract management scenarios. The guidance is intended to help colleagues brief incoming ministers. The introduction to the Principles explains: "Third party suppliers have a vital role in delivering the Government's agenda, attracting one third of Departmental spend. Ministers have a vital role in setting commercial priorities, making sure that the right suppliers are chosen to address the right requirement and managing contracts to achieve the performance and value required. Ministers should hear from and challenge suppliers, making sure that they understand the strategic intent behind policy, and that supplier solutions make appropriate tradeoffs between cost, risk and quality. Ministers can give suppliers confidence in the process and encourage suppliers to treat Government as a strategic partner. Ministers can also set red lines; making it clear that suppliers who are receiving public money must meet Government's ethical, environmental and social standards".

3.93. "It is therefore imperative that Ministers be involved in commercial activity. Ministerial involvement in the development of commercial strategies should be actively sought by officials. Evaluation criteria should be designed to reflect ministerial priorities for the goods or services being procured, including criteria such as delivery of social value and use of SMEs. Ministers should meet key Departmental suppliers and make it clear

[81] GRW/71 - [INQ000471040]

what is needed of them. Departments should enable such involvement in a way that supports Ministerial ambition and accountability while maintaining public trust in the integrity of Government's commercial dealings. This guidance steps through four stages of commercial activity and offers advice on how to maximise the value of Ministerial involvement while maintaining the necessary safeguards".

3.94. The principles confirmed how Ministers can avoid or limit potential conflicts of interest. The four stages it covers are:

3.94.1. Ministerial involvement before procurement starts;

3.94.2. Ministerial involvement during a procurement process;

3.94.3. The contract award stage; and,

3.94.4. Ministerial involvement in contract and supplier management post contract signature.

3.95. Specifically the principles clarified that, during a procurement process, Ministers should not:

3.95.1. Seek to influence the procurement process so that for example the requirement, timing and choice of procedure favours one particular supplier over another.

3.95.2. Express a preference for a particular supplier or subset of suppliers (or a preference against certain suppliers) during the selection process based on anything other than the evaluation of a supplier's response against the published selection and award criteria.

3.95.3. In circumstances where Ministers wish to dismiss or reject the recommendations of the procurement team (e.g. down selection), not proceed without taking commercial, financial and legal advice to ensure they are adhering to requirements about correct use of public resources.

3.95.4. Take direct representations from involved suppliers or business associations during the process. Ministers should be aware that procurement processes, including the need for equal treatment, require such representations to be dealt with by the procurement team.

3.96. In addition, the Procurement Act 2023 includes greater obligations on authorities in respect of transparency around conflict of interests and safeguards to protect against

fraud and conflict of interests in cases of direct awards. Further details are provided in Section G of this statement.

Investigations carried out by the Cabinet Office internally

Ministers

3.97. In the relevant pandemic period, from January 2020 to 28 June 2022, there are no records of concerns being raised in relation to ministerial declarations of interests and potential conflicts of interest with regards to Covid procurement that were determined to warrant a formal, Prime Minister-commissioned investigation, under the process set out in the Ministerial Code. Accordingly, no records are held of investigations under the Ministerial Code that were carried out internally in relation to ministerial declarations of interests and potential conflicts of interest with regards to Covid procurement during the relevant period.

3.98. Investigations into alleged breaches of the Ministerial Code, including in relation to interests issues, can be conducted according to the Ministerial Code: “if there is an allegation about a breach of the Code, and the Prime Minister, having consulted the Cabinet Secretary, feels that it warrants further investigation, the Prime Minister may ask the Cabinet Office to investigate the facts of the case and/or refer the matter to the Independent Adviser on Ministers’ interests.”

3.99. The term “investigations”’ in relation to ministers’ interests therefore does not, in this context, include any routine or other advice about a minister’s interests that might have been given in the period, by the relevant permanent secretary, any other officials, or the Independent Advisers on Ministers’ Interests.

3.100. Two Independent Advisers on Ministers’ interests served during the pandemic period: Sir Alex Allan (November 2011 to November 2020) and Lord Geidt (April 2021 to June 2022). Details of any investigations conducted by Independent Advisers are typically set out in their respective annual reports. The annual reports of this period indicate that no investigations relating to ministers’ declarations of interest or potential conflicts were conducted by Alex Allan or Lord Geidt during the timeframe in question, as set out in the Independent Adviser’s Annual Report of May 2021: “Since my predecessor's last Annual Report in December 2019, there has been one investigation which has been referred to the Independent Adviser under the Ministerial Code process, namely the investigation into the conduct of the Home Secretary. My predecessor's findings in respect of that investigation were published in full on 20 November 2020 and are

available on gov.uk and at Annex A."[82]

3.101. The 2021 report includes a consideration of the then Secretary of State for Health and Social Care's declaration of his 20% stake in Topwood Ltd, a company owned and run by the then Secretary of State's sister and brother-in-law, however this was not described by the then Independent Adviser as an investigation. The Independent Adviser's assessment of this declaration can be found in the body of the report at paragraphs 35-37.

3.102. Lord Geidt's Annual Report of May 2022 confirms that since the 2021 report, he was asked by the Prime Minister to provide advice on three issues, none of which are related to conflicts of interest in relation to COVID-19 procurement.[83]

3.103. Similarly, there are no records of the Cabinet Office being asked by the Prime Minister to conduct any fact-finding investigations, as set out in the Ministerial Code, into conflicts of interest in relation to COVID-19 procurement, during the relevant period.

[82] GRW/72 - [INQ000477288]
[83] GRW/73 - [INQ000477275]

4. SECTION D: ROLES AND RESPONSIBILITIES RELATED TO PROCUREMENT DURING THE PANDEMIC

i) The Ventilator Challenge

Introduction

4.1. In early March 2020, the advice from SAGE was that, in a reasonable worst case scenario ('RWCS' - a tool used for planning purposes to illustrate the worst manifestation of a risk that can reasonably be expected potentially to occur based on current information and data), the excess deaths from COVID-19 would be 520,000 within 3 months and that 781,000 people would require ventilation at some point while hospitalised.[84]

4.2. It had become apparent, from the rise in hospitalisations in Europe and the UK, that ICU beds and ventilators (i.e. medical devices that move air into and out of the lungs) would be critical for treating those suffering with COVID-19. Ventilators could be used to take over the body's breathing process when COVID-19 caused the lungs to fail and thus allow patients time to fight off the infection and recover.

4.3. DHSC determined the need for ventilators based on the RWCS, which estimated that 30,000 ventilators were required by April 2020 and 90,000 ventilators were required by November 2020.[85] In March 2020, it was tentatively estimated by DHSC and NHSE/I that the NHS had access to 6,000 to 8,000 ventilators across the whole of the UK.[86]

4.4. Prior to the pandemic, the purchasing of ventilators (along with most other medical equipment) was carried out by individual NHS Trusts. There was no central list of how many ventilators were held by the NHS or what model or specification they were or whether they were functioning. Based on the data from SAGE's modelling, the NHS would not have enough ventilators to treat patients with COVID-19 who would require them.

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[84] GRW/74 - [INQ000279737]
[85] On 22 March 2020, DHSC provided data on the projections for ventilators GRW/75 - [INQ000477911]. The figure for 40% compliance with wider social isolation (which was the assumption subsequently used in daily reports to Ministers, see the report on 29 March 2020 GRW/76 - [INQ000513011]) included a peak of 72,155 ventilators by 27 November 2020 (week 42) GRW/77 - [INQ000478784]
[86] GRW/78 - [INQ000411831]

4.5. On 12 March 2020, the Secretary of State for Health had a call with the Prime Minister and the Chancellor of the Duchy of Lancaster (CDL). Coleen Andrews, Director of Markets and Suppliers in the GCF in Cabinet Office, and Steve Oldfield, Chief Commercial Officer at DHSC, also attended. On this call, there was a discussion of the urgent need for ventilators and the idea arose of getting a group of UK-based companies to assist with manufacturing more ventilators.[87] The concern was that, having seen northern Italy suffer from a shortage of ventilators during the initial surge of COVID-19, the UK would run out of ventilators.

4.6. The Government was already struggling to purchase ventilators on the market.[88] The global demand for ventilators meant that there was no confidence that significant numbers of ventilators could be sourced from existing producers. As well as a shortage of ventilators, it was also likely to be difficult to purchase key materials for ventilators. I thought we should set up a project to at least try to design and manufacture the missing volume.

4.7. On the morning of 13 March 2020 I emailed Patrick Vallance, the Chief Scientific Adviser, and Steve Oldfield to seek their thoughts on the merits of an idea to assemble a team of engineers to design a new, simple, mass-manufacturable ventilator.[89]

4.8. The initial idea I had proposed was for a non-invasive ventilator to be used at home by patients (a so-called “bag squeezer”). However, Steve Oldfield replied stating that the biggest need was for higher-end invasive mechanical ventilators. I suggested that a separate team be set up to manage a rapid design project, given the numerous other demands on the DHSC procurement team.[90]

4.9. As far as I can recall, I had a phone call with Sir John Manzoni, the Chief Executive of the Civil Service and Permanent Secretary of the Cabinet Office, on the evening of Friday 13 March 2020. We discussed adopting a two pronged, centrally-led approach to securing more higher-end ventilators for the NHS (as part of a wider ‘oxygen, ventilation, medical devices and clinical consumables’ programme):

4.9.1. First, to buy as many ventilators as possible from both UK and global suppliers. This exercise to buy existing ventilators was led by DHSC. A

[87] GRW/79 - [INQ000146639]
[88] GRW/80 - [INQ000471001]
[89] GRW/80 - [INQ000471001]
[90] GRW/81 - [INQ000471016]

Joint Unit was established to secure overseas opportunities for the purchase of ventilators with the FCO, DIT and DHSC. The Cabinet Office had limited or no direct participation in the actual ventilator buying effort. Since the purchase of ventilators from the market was a DHSC-led project, all checks needed, including for Conflicts of Interest, were DHSC's responsibility.

4.9.2. Second, to work with suppliers and manufacturers based in the UK to increase the production of ventilators in the UK. At the time of the pandemic, there were no large scale domestic producers of ICU mechanical ventilators, or domestic companies with current lines of ICU mechanical ventilators licensed for sale in the UK. This second approach was called "the Ventilator Challenge" and was to be led by the Cabinet Office. I mentioned that we might need billions to achieve this, based on the then current market price of c.£20,000 for a ventilator.[91]

4.10. The Cabinet Office led on the Ventilator Challenge because:

4.10.1. I personally had experience of running research and development intensive businesses and of manufacturing complex electromechanical products and bringing them to market;

4.10.2. The CTT sat within the GCF in the Cabinet Office and had staff with significant commercial experience and expertise. The GCF team worked closely with a team of clinicians from the NHS, officials from DHSC and the Medicines and Healthcare products Regulatory Agency (MHRA, an ALB of DHSC) throughout the project; and

4.10.3. The Cabinet Office had available resources (initially around 10 to 12 people).

4.11. There were two approaches taken to meeting the Ventilator Challenge:

4.11.1. Identifying and then increasing the production of existing designs, adapting these where necessary.

4.11.2. Developing new designs for ventilators that could be manufactured quickly and which ideally, did not require components that might overlap and compete with each other or with existing ventilator designs.

[91] GRW/82 - [INQ000497221]

4.12. For both of the above, it was necessary to secure the approval of MHRA for all new or adapted designs. The MHRA is the independent regulator of medical devices in the UK.

Governance and reporting chain

4.13. As the GCCO, I was the Senior Responsible Officer for the Ventilator Challenge given my procurement role and private sector engineering background.

4.14. The day-to-day operations were managed by the "Ventilator Challenge team" comprising:

4.14.1. Clare Gibbs, Director of the Sourcing Programme, a Senior Commercial Specialist and part of my GCF team in the Cabinet Office, who was the Project Manager and provided general senior oversight.

4.14.2. Dan Webster, a Deputy Director and Commercial Specialist in the Complex Transaction Team of the GCF and part of my team in the Cabinet Office, who was the Commercial Specialist for all the contracts with suppliers.

4.14.3. Staff at delegated grades who provided PMO support for the Ventilator Challenge.

4.14.4. Frazer Bennett, Simon Collier and Barbara Bradley, Partners at PA Consulting, whose role is explained at paragraphs 4.23 and 4.24 below.

4.15. The Cabinet Office Ministers involved in the Ventilator Challenge were: Lord Agnew (Minister of State for the Cabinet Office), Michael Gove (Chancellor of the Duchy of Lancaster) and Boris Johnson (Prime Minister).

4.16. The Ventilator Challenge held daily core team meetings with those involved in the day-to-day operations to set the key tasks and objectives for the day. There would then be regular catch ups throughout the day. The reality was that the team was working almost 24/7.

4.17. The day-to-day operations team then reported to me (via Clare Gibbs) and I reported to Lord Agnew, as the Minister.

4.18. There were daily meetings with me, Lord Agnew, Dan Webster, Clare Gibbs and Frazer Bennett and Barbara Bradley from PA Consulting from 22 March 2020 which received a standard pack showing anticipated delivery dates of and the key

milestones/issues with each design. From 20 April 2020, the frequency of these meetings was reduced to 3 times a week.

4.19. Progress on the Ventilator Challenge was also reported to Emily Lawson, the Chief Commercial Officer of NHSE/I and Jonathan Marron, Director General in DHSC, who were in charge of the DHSC's initiative to obtain oxygen and ventilation supplies for the NHS in response to COVID-19, as shown by the organisation structure chart in the PMO Programme Process and Structure Pack for the Ventilator Challenge.[92]

4.20. Political interest in the Ventilator Challenge was acute, necessitating careful analysis of likely delivery dates and volumes. The normal optimism of suppliers had to be balanced with realistic views of when their products might pass MHRA tests, when the manufacturing process would be approved and the availability of required components.

The goal of the Ventilator Challenge

4.21. In mid-March 2020, the initial view taken by the DHSC, based on the RWCS figures provided by SAGE, was that 30,000 ventilators were required by April 2020 and up to 90,000 by November 2020.[93] These numbers were so big in comparison to the estimates of existing NHS stock that there was no conception at this stage that the Ventilator Challenge could produce too many ventilators.

4.22. Practically, therefore, the Ventilator Challenge was working to obtain and manufacture as many compliant ventilators as possible as quickly as possible.[94] The Ventilator Challenge sought to pursue all realistic alternative routes to achieve this goal.

4.23. In order to launch the Ventilator Challenge, it was necessary to seek the assistance of consulting support who could undertake project management and had the required understanding of medical technology. PA Consulting was an existing supplier across the Government with this dual expertise. It was ideally placed to help because it had a group which specialised in product development and had a research and development site outside Cambridge where a number of med-tech companies are based.

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[92] GRW/83 - [INQ000477239]
[93] GRW/74 - [INQ000279737]
[94] GRW/84 - [INQ000477233]

4.24. PA Consulting began to support the Ventilator Challenge from 13 March 2020, provided a proposal for support on 15 March 2020,[95] and on 16 March 2020 they were formally engaged by a direct award under a CCS Framework to provide a role to include project management, technical expertise, logistics and communications activities.[96] This allowed the Cabinet Office officials to focus on decision making.

Targeted "call to arms"

4.25. The objective of the Ventilator Challenge 'call to arms' was to seek support from a group of key manufacturers and suppliers in the medical technology industry.[97] The Cabinet Office, working with Innovate UK and PA Consulting started by contacting the companies whom it was thought could help.[98]

4.26. This initial list of design consultancy companies had expertise in medical design or rapid manufacturing. The list included: TTP Consulting, Team Consulting, Sagentia and Cambridge Consultants. Unipart and Metlase were also included as consultants to support the supply chain and procurement. Unipart in particular was contacted because of its experience of scaling up manufacturing.

4.27. All of these consultants, other than Unipart, are part of the so-called "Cambridge Cluster" of medical technology companies. These consultants deployed teams of scientists and engineers who worked collaboratively to support the Ventilator Challenge.

4.28. The first call with these design consultants (PA Consulting, TTP Consulting, Team Consulting, Sagentia and Cambridge Consultants) was held on Friday 13 March 2020.[99] I attended this call along with Steve Oldfield, Chris Stirling (DHSC Commercial), Emily Lawson (NHSE/I Chief Commercial Officer) and David Simmons (DHSC Supply Chain Resilience). The goal of the Ventilator Challenge was explained along with the need for the designers to cooperate in order to maximise the slim chances of timely success.

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[95] GRW/85 - [INQ000505995]
[96] GRW/86 - [INQ000497262] As well as its project management role, PA Consulting subsequently briefly participated in the Ventilator Challenge as a design consultant. However, as explained in the Regulation 84 report GRW/87 - [INQ000477277] it was decided that it was not a conflict of interest because the project management role was carried out by a different team at PA Consulting comprising different people with a different skill set. The ventilator design supported by PA Consulting's healthcare team was anyway de-selected relatively quickly during the first TDA reviews in late March 2020.
[97] GRW/88 - [INQ000496686]
[98] GRW/89 - [INQ000496685]
[99] GRW/90 - [INQ000496687]

4.29. Also on 13 March 2020, DHSC circulated a draft indicative (work in progress) specification for a rapidly manufactured ventilator system ("RMVS") for the new designs to be based on.[100]

4.30. Discussions between Ministers, officials and the design consultants over the weekend of 14-15 March 2020 suggested that the goal to manufacture safe and effective ventilators at pace was potentially achievable if very ambitious.[101] These design consultants were engaged on a rates basis plus reimbursement of their documented reasonable costs. These companies were also asked to tell us about other companies in their sector (which was relatively small) who could also help.[102]

4.31. Initially it was thought that a relatively simple design would be better. This was referred to as the Minimal Viable Product. A simple design was more likely to be completed quickly and thus meet the urgent requirement for ventilators at that stage. For example, the initial specification referred to an article which described an emergency ventilator developed by a consultant anaesthetist in the NHS in 2010.

4.32. However, as I explain further below, this was judged by the clinicians and MHRA experts who became part of the Ventilator Challenge to be too simple and the specification evolved rapidly.

4.33. By Monday 16 March 2020, a list of companies who might be able to help had been compiled by the Business Team in No.10 led by Oliver Christian.[103] This list included existing contacts identified by the Cabinet Office with the assistance of PA Consulting. Other contacts were added by the Business Team in No.10 and MakeUK.[104] The Prime Minister convened a meeting with c.60 leading manufacturers and suppliers to encourage them to participate in the Ventilator Challenge and ask for the names of further potential companies, as well as for ideas on designs. For example, the Ventilator Challenge was put in touch with Smiths Medical by JCB, Dyson and Renishaw (who were all part of the initial list).

Wider public request for help

4.34. On 16 March 2020, the Department for Business, Energy & Industrial Strategy (BEIS) also published a wider call for businesses to help make NHS ventilators on

[100] GRW/91 - [INQ000477234], GRW/92 - [INQ000477235]
[101] GRW/93 - [INQ000478812], GRW/94 - [INQ000496693]
[102] GRW/95 - [INQ000496688]
[103] GRW/96 - [INQ000477906]
[104] GRW/97 - [INQ000496691], GRW/98 - [INQ000496692]

the gov.uk website.[105] The request was made to manufacturers and also for businesses with skills in “design / specification”, “rapid prototyping”, “contract / product assembly”, “certification / regulation / testing”, “logistics”, and “medical training”. Businesses were asked to register their details if they could help.

4.35. The Government received over 5,300 offers of support in a dedicated mailbox in response to this wider request for help. All these offers were recorded in a live database. A snapshot of the final version of this database is exhibited to this statement.[106]

4.36. This public request for help was secondary to the targeted approach to the leading suppliers and manufacturers in the industry, however it did produce a few less obvious suppliers, and some who had been missed from the initial call (for example I personally contacted OES Medical on 20 March 2020 after I had seen them on Newsnight on 19 March 2020 saying that no one had yet contacted them). It also led to offers of support from those who produced components, and some offers for ventilators which the Ventilator Challenge forwarded on to the DHSC team leading on the procurement of existing ventilators.[107]

Selection of suppliers

4.37. The Ventilator Challenge team had to identify from the potential suppliers those who had a realistic prospect of meeting the RMVS Specification within the required timeframes, with a design that could be scaled up rapidly, and so should be chosen to participate in the Ventilator Challenge.

4.38. On 18 March 2020, the MHRA published the first revision of the RMVS Specification (which was now under its remit).[108] The MHRA had emergency powers to permit the use of medical equipment that, for example, was not CE marked under its “exceptional use authorisation”.

4.39. The RMVS Specification was regularly updated by the MHRA and evolved over the course of the Ventilator Challenge programme as the clinical information in relation to the symptoms of COVID-19 increased. The extra functionality and requirements which the clinicians required ultimately meant that the final requirement was for a

[105] GRW/99 - [INQ000471044]
[106] GRW/100 - [INQ000477250]
[107] GRW/101 - [INQ000478788]
[108] GRW/102- [INQ000477251]

relatively complicated ventilator (meaning the simpler new designs which had started under the initial RMVS specification were generally not suitable).

4.40. The Cabinet Office was not involved in making decisions about the clinical specification in the RMVS Specification. The MHRA was in charge of determining what an adequate or acceptable machine had to do, in what circumstances, and under what conditions it had to be manufactured.

4.41. Researching the lists of UK based manufacturers who were licensed to sell appropriate ventilators in the UK yielded a nil return, leading to the initial conclusion that we would have to start every project from scratch. However, within a number of days, it became clear that there were several vendors that were likely to be suitable for support in the Ventilator Challenge, because they had an existing product or were very close to having one. In particular:

4.41.1. Penlon, who did not have a ventilator product, but did have an anaesthesia machine, which had component modules that could be reformed into a ventilator.

4.41.2. Diamedica, who had a simple ventilator product that was not licensed in the UK, but was being sold in Africa.

4.41.3. OES, who had a 'late-stage prototype' based on an earlier anaesthesia machine, but which did not yet have any formal approvals.

4.41.4. Smiths Medical, who had the Parapac, a transport ventilator used by ambulance crews, which is not suitable to keep patients on for any length of time, but was already in UK manufacture. The issue with this product was how to scale it up effectively from its current low volume.

4.42. There were two steps to the initial selection of suppliers.

4.42.1. First, the responses were triaged by PA Consulting.[109] PA Consulting triaged the offers of support using a multi-step process. Initially a Python script[110] was used to identify potentially suitable offers, followed by a two-step human scan to validate the offers and identify any that had been missed.[111] There were 63 offers received for an RMVS design or

[109] GRW/103 - [INQ000496720]
[110] A computer programming language often used to build websites and software, automate tasks, and conduct data analysis.
[111] GRW/104 - [INQ000496727]

prototype (as listed in a tracking sheet).[112] The task to sift through the 63 offers could be carried out quickly due to the small, specialist market in the UK (and, indeed, globally). There are around 20/30 companies in the UK who make medical devices and around 30/40 who make components to go in such medical devices. Most of the chosen suppliers had been identified and approached by the Ventilator Challenge team, rather than responding to the public "call to arms".

4.42.2. Second, 25 potential designs identified by the initial triage were subject to a review by the Technical Design Authority (TDA) that we established for the Ventilator Challenge. The objective of the TDA was to make recommendations to ministers based on clinical observations.[113] The suppliers did not attend the TDA, however each supplier provided a PowerPoint document explaining their proposal and some also provided prototypes, drawings, models or animations. The TDA held three initial sessions to decide which suppliers to proceed with on 18 March 2020, 20 March 2020 and 23 March 2020. PA Consulting produced minutes of the TDA meetings.[114]

4.43. On 18 March 2020, there was also a wider design and brainstorming day at PA Consulting's offices in Cambridge, attended by many of the teams.

4.44. The TDA was chaired by PA Consulting (Simon Collier) as part of its project management function and included:

4.44.1. The Clinical Director of Medical Devices at the MHRA (Duncan McPherson);

4.44.2. 5 senior clinicians, led by Professor Ramani Moonesinghe, the head of ICU for the NHS. The clinicians were chosen by DHSC / MHRA;

4.44.3. Professor Tom Clutton-Brock, a Professor of Anaesthesia and Intensive Care Medicine at the Institute of Clinical Sciences at the University of Birmingham and a Director of the Medical Devices Testing and Evaluation Centre (MD-TEC). Professor Tom Clutton-Brock was a leading figure in the testing of medical devices in the UK and led a team which subsequently carried out the medical testing of all the ventilators;

[112] GRW/105 - [INQ000478796]
[113] GRW/106 - [INQ000477909], GRW/107 - [INQ000477930]
[114] GRW/108 - [INQ000506000], GRW/109 - [INQ000513004], GRW/110 - [INQ000496715]

4.44.4. Senior representatives from the Cabinet Office (myself, Dan Webster or Clare Gibbs). The Cabinet Office officials were not involved in making clinical judgments. However, we led on the decision making based on these clinical judgments and input from the MHRA (as regulator), the testing team and the teams working on supply chain and manufacturability.

4.45. Through this process, by late March 2020, 14 designs had been selected to move forward with. These designs were presented to the Prime Minister at the 9.15am COVID-19 strategy meeting on 27 March 2020:[115]

#	Device	Designer	Potential Manufacturer	Proposal
1	Prima ES02	Penlon Limited ("Penlon")	HVM Catapult (Ford, Siemens, McLaren, Meggit)	New device built from core modules of an existing anaesthesia ventilator.
2	Helix	Diamedica	Plexus	Scaled up version of existing device
3	Mosquito	Sagentia	Sagentia	New design
4	EVA (initially called "Jarre Head")	TEAM Consulting (based on a Diamedica design)	Cogent	New design
5	Lifeline Remora (subsequently called Blue Sky)	Darwood IP	Innovate UK, Pitlane Consortium (all 7 UK based F1 teams), Olympus.	New design
6	ParaPac 300	Smiths Medical	Smiths Medical	Scaled up using additional manufacturing from Airbus GKN/ Rolls Royce
7	CoVent	TTP	Dyson	New design
8	Zephyr+	Draeger	Babcock	Adapted version of an existing

[115] GRW/111 - [INQ000088311], GRW/112 - [INQ000512989]

				Draeger device
9	Belavista/ iX5	Vyaire		Existing device
10	Nippy4+	Breas Medical	Breas Medical	New design just launched by Breas
11	Vivo65	Breas Medical	Breas Medical	Existing design
12	Gemini	OES Medical	BMW	Adapted version of an existing device
13	Apollo 13 (subsequently became Veloci-Vent)	Cambridge Consultants Ltd	MetLase (Unipart)	New design
14	OxVent	King's College London and Oxford University	Smith & Nephew	New design

4.46. Out of the 14 designs referred to above:

4.46.1. The existing Vyaire Belavista/iX5 ventilator, manufactured outside of the UK, was referred to DHSC to try to procure.

4.46.2. The Zephyr+ design by Draeger and Babcock was managed by MoD.

4.47. The decision was made at this stage not to pursue any paediatric ventilators because they were considered to be too complicated.

4.48. The Ventilator Challenge had also identified additional non-mechanical ventilator, products, including:

4.48.1. A mask (pressure cycled automatic ventilator system) called InVicto produced by JFD which was a new design based on diving masks.

4.48.2. A CPAP device called "SOG" by Vobster Marine Systems.[116] CPAP was being used to treat COVID-19 more than anticipated, and it used significant oxygen, generating a reasonable threat to oxygen supply in the NHS. A CPAP device using a Closed-Circuit Rebreather (such as is used in aqualungs) allows exhaled oxygen to be reused.

[116] A CPAP device stands for continuous positive airway pressure.

4.49. A number of the offers of support were not from medical companies.[117] One element of the Ventilator Challenge was matching those companies with experience and expertise of manufacturing high quality products at scale, with the designers of the ventilators. For example, Penlon was a medical supplier with experience of producing anaesthesia ventilators but at a tiny scale compared to the scale required. The Cabinet Office secured support for it from Ford Motor Company Limited, McLaren Racing Limited, Siemens, Airbus and others who had capability to manufacture at scale. These companies volunteered to help and were chosen because of their experience in manufacturing high precision products with robust quality control and often in a regulated environment. The allocation of manufacturing partners to designs and designers was based on dialogue with the design teams and manufacturers, and was largely driven by (i) the maturity of the design and (ii) the readiness of any in-house manufacturing capability that the designers had already. Manufacturers were deliberately allocated to only one design to maintain focus of their effort and assistance. The intention was to use the expertise of the partners to scale up manufacture in existing facilities (such as Penlon's factory) that were already certified to make medical devices. Obtaining such approval for another facility (for example a precision manufacturing workshop making parts for Formula 1 cars) would have been another time and effort-consuming step.

4.50. Other potential suppliers were only identified in April 2020, such as:

#	Device	Designer	Potential Manufacturer	Proposal
15	Florence (later renamed AirCare)	BAE Systems	InterSurgical	New design
16	Piranvent	Swagelok	Sagetech	New design
17	LTV2	Vyaire	N/A	Existing design (only used in Japan pre-pandemic)

4.51. Formal correspondence was issued to the selected suppliers. The type of correspondence issued varied for different suppliers:

[117] GRW/103 - [INQ000496720]

4.51.1. A confirmation of order was issued to Penlon Medical, because it already had a potentially viable ventilator design built from pre-existing modules contained in other established products, so was more straightforward than the other suppliers' proposals.[118]

4.51.2. Suppliers who had a tangible product (e.g. a prototype) which required adjustments were generally issued a letter of commitment and/or a letter of intent.

4.51.3. Suppliers who were producing an entirely new design were generally issued a letter of comfort. As an exception, Dyson received a contingent order (see table at paragraph 4.51.4) following an instruction to me from the Chancellor of the Duchy of Lancaster to place an order for 10,000 units.[119] Ministers thought it was important to give Dyson, as a noted and successful inventor, a chance to demonstrate its product's capabilities. The order was contingent because at the time it was issued, Dyson, working with TTP, had not yet submitted a prototype, so the order was contingent on its design successfully passing MHRA tests by a certain date.[120]

4.51.4. The correspondence issued to the different selected suppliers is shown by the table below. These letters contain the conditions under which production contracts would be awarded.

Supplier/ Device	**Type of Engagement Document**	**Date Issued**
Smiths Medical Parapac	Letter of Commitment[121]	23 Mar 2020
Dyson / TTP Covent	Contingent order letter[122]	25 Mar 2020
Penlon ES02	Confirmation of Order[123]	26 Mar 2020
Babcock /Draeger Zephyr+	Letter of Commitment[124]	26 Mar 2020

[118] GRW/113 - [INQ000480110]
[119] GRW/114 - [INQ000496699]
[120] GRW/115 - [INQ000497223], GRW/116 - [INQ000496735]
[121] GRW/117 - [INQ000477913]
[122] GRW/118 - [INQ000477912]
[123] GRW/113 - [INQ000480110]
[124] GRW/119 - [INQ000477918]

Sagentia Mosquito	Letter of Intent[125]	26 Mar 2020
Team Jarrehead Revision of Diamedica Helix	Letter of Commitment[126]	26 Mar 2020
Diamedica/Crimino Helix	Letter of Commitment[127] Commercial cover letter[128]	26 Mar 2020 27 Mar 2020
Breas Medical Ltd Vivo65 & Nippy4+	Letter of Comfort[129]	27 Mar 2020
Darwood IP Blue Sky	Letter of Commitment[130]	27 Mar 2020
Cambridge Consultants Ltd Veloci-Vent	Cambridge Consultants signed design contract[131]	27 Mar 2020
KCL/Oxford University OxVent	Letter of Commitment[132]	29 Mar 2020
OES Medical Gemini	Letter of Commitment[133] Letter of Intent[134]	10 April 2020 10 April 2020

4.52. A letter of comfort was also issued to Vobster Marine Systems for its CPAP device on 9 April 2020.[135]

4.53. Letters of commitment or comfort were issued because of the urgency of the situation, and the uncertainty as to which suppliers would be successful to develop a compliant machine that could also be manufactured at sufficient scale and speed.

[125] GRW/120 - [INQ000477914]
[126] GRW/121 - [INQ000477915]
[127] GRW/122 - [INQ000477916]
[128] GRW/123 - [INQ000477238]. This was issued to Plexus, the intended manufacturer, to authorise spend up to £10m to purchase the necessary components.
[129] GRW/124 - [INQ000480112]
[130] GRW/125 - [INQ000477919]
[131] GRW/126 - [INQ000512990]
[132] GRW/127 - [INQ000477260]
[133] GRW/128 - [INQ000477923]
[134] GRW/129 - [INQ000477924] Following submission of this corporate statement it has been clarified that these letters to OES Medical Gemini were drafts and not sent. Please refer to the subsequent Cabinet Office corporate statement [INQ000528389] dated 20 December 2024, for the correct letter that was sent to OES Medical Gemini dated 30 April [INQ000562375]
[135] GRW/130 - [INQ000477934]

This meant that design work, testing, and development of relevant manufacturing processes had to be undertaken before a formalised contract with known costs and outputs could be put in place between the Cabinet Office and the eventually successful suppliers. These letters can be found in the table above at paragraph 4.51.4.

4.54. Where necessary, we also issued correspondence giving commercial comfort (that we would cover reasonable costs) to those involved in the supply chains or who were supporting the suppliers or assisting the Ventilator Challenge generally. See paragraph 4.51.4 for this correspondence.

4.55. The commitments provided by the various letters were to enable the suppliers (and their supply chains) to support the Ventilator Challenge at significant pace and to prevent those suppliers from operating entirely at risk during extremely turbulent and challenging circumstances. Under these letters, the Government agreed to pay the suppliers for their reasonable costs incurred in undertaking the work.

4.56. The letters of intent, commitment and comfort further stated that the Cabinet Office was committed to purchasing ventilators if they met the RMVS specification and obtained regulatory approval from the MHRA.

Managing suppliers

4.57. Each selected supplier was assigned a dedicated team from the Ventilator Challenge to assist it. A Cabinet Office official would generally be working as the commercial lead for a few different suppliers. The Cabinet Office commercial lead for each project was closely involved with that project (a “man-marking” approach) in order to advance progress and control spending. They were responsible for the commercial decision making, escalating decisions and approvals for spending to senior civil servants and the SRO where necessary.

4.58. Each Cabinet Office commercial lead was supported by: (a) two to six consultants from PA Consulting providing project management (organisation and delivery of TDA decision-making governance), supply chain support (analysis of Bills of Materials and support to identify critical/short supply items including sourcing those) and manufacturing development support (support to projects in designing manufacturing processes), (b) legal support from the Government Legal Department, and (c) cost/auditing support from the Ministry of Defence’s Cost Assurance & Analysis Service (“MoD’s CAAS”).

4.59. As a result, the number of people working in the Cabinet Office on the Ventilator Challenge peaked (briefly) at around 120 to 160 people for one week. These were mainly consultants and engineers provided by PA Consulting. Dan Webster had a weekly meeting with the lead partners at PA Consulting to review and refine resourcing based on reports produced by PA Consulting.[136] The number and type of support was continually adapted based on need.

4.60. The COVID-19 Key Contacts and Workstream List issued on 20 March 2020 identified the different people who had been assigned to 12 different projects (counting the Breas Medical Nippy 4 and Vivo65 as a single project).[137] An organogram dated 1 April 2020[138] sets out the Product Lead, Project Manager, Technical Lead, Finance Lead and Sourcing Supply Chain lead for these 12 projects.

4.61. A team from the MoD's CAAS was engaged to audit and provide an opinion on the reasonable costs incurred by certain suppliers and design consultants' costs, including Penlon (and its supporting companies), Smiths Medical (and its supporting companies), Plexus, Sagentia and Smith & Nephew (part of the OxVent design).[139]

4.62. While the Ventilator Challenge team knew from the start that not all of the projects would be viable or successful, the approach taken was to give every supplier everything they needed to be successful, hoping to get one design that would pass the MHRA tests.

4.63. The message given to the Project Managers for each project was to ask the suppliers on a regular basis: what else do you need to make this happen more quickly?

4.64. Suppliers were therefore asked to identify what they considered to be the key risks and key steps, including any components which were considered higher risk (i.e. which they may not be able to obtain in time), such as precision valves and airpath components. The Cabinet Office support provided assistance in seeking to avoid or mitigate these risks, for example by ensuring that the bills of materials for the different designs did not overlap or conflict. On occasion, the Cabinet Office advanced sums to design teams to enable them to buy components that either had long lead times or were in danger of selling out. For example, on 26 March 2020 an

[136] GRW/131 - [INQ000497264], example on slide 10
[137] GRW/132 - [INQ000477243]
[138] GRW/133 - [INQ000478790]
[139] GRW/134 - [INQ000478819]

advanced payment of circa £1.3m for set up costs and circa £5.1m to order items with long lead times were processed for Penlon.[140] All commercial activity was recorded in the Commercial Activity Log and upfront fees are shown in columns T & V of the Log exhibited.[141] The MoD's CAAS team undertook a financial health check on all those who received pre-payments.[142]

4.65. Ventilators can include thousands of components. A key part of the challenge was to produce or acquire the necessary components because components for ventilators were as scarce on the market as ventilators themselves. For example, in March 2020 Breas Medical identified that the supplier of the blower for its ventilators was considered higher risk.[143] The Cabinet Office therefore worked with Breas Medical to identify an alternative supplier of blowers.[144]

4.66. A team from PA Consulting was looking at procurement of components generally. The new designs were therefore challenged to be unique, using components which were available and not part of existing ventilators as we were aware that other countries would also be attempting to design and produce new ventilators (as India and the United States did). PA Consulting also carried out a detailed exercise of identifying what components could be purchased from where. The items were purchased by the suppliers and not directly purchased by the Cabinet Office.

4.67. The suppliers were also encouraged to communicate and collaborate with each other, including sharing ideas where a supplier had produced a particularly innovative design. Generally, intellectual property created by suppliers in the performance of ventilator design contracts with Cabinet Office vested in the Cabinet Office. Pre-existing Intellectual property rights created by suppliers and brought into the designs remained the property of those suppliers, although the Cabinet Office has a licence to use such intellectual property to the extent it formed part of the contract deliverable and its use is reasonably required to take the benefit of the relevant contract.

Changing Targets

[140] GRW/135 - [INQ000480110], GRW/136 - [INQ000497224]
[141] This was a live document, so only snapshots in time are available. For the Penlon example explained, the payments are logged in GRW/X - [INQ000512988] dated 26 March 2020. GRW/X - [INQ000497269] provides the latest snapshot of the activity log.
[142] GRW/139 - [INQ000497222]
[143] GRW/140 - [INQ000512987]
[144] GRW/141 - [INQ000513012]

4.68. The scope of the Ventilator Challenge at this stage reflected the changing data received from DHSC.

4.69. The projections from NHSE/I received by the Cabinet Office on 22 March 2020 showed:

4.69.1. An initial peak need for 3,664 ventilators by 13 April 2020.

4.69.2. A second peak need for 15,237 ventilators by 5 June 2020.

4.69.3. An ultimate peak requirement of 72,155 ventilators by 27 November 2020.

4.70. By 23 March 2020, the NHSE/I's projection, based on 40% compliance with the social isolation measures that had by then been introduced, was that 16,900 ventilators would be required in April 2020.[145] The initial objectives of the Ventilator Challenge were therefore to deliver:[146]

4.70.1. 8,000 MHRA approved new ventilators by 13 April 2020 (it was recognised that delivery of this initial target by this date was always a significant challenge).

4.70.2. 30,000 MHRA approved new ventilators by 30 April 2020.

4.70.3. 80,000 MHRA approved new ventilators at the point of the expected second peak in November 2020.

4.71. One of the actions following the COVID-19 Strategy Ministerial Group Meetings (the daily 9.15am meetings)[147] on 24 March 2020,[148] and 25 March 2020[149] was for DHSC to provide a paper setting out the overall position on ventilators, including detail on the pipeline and timeline of supply.

4.72. An update received on 26 March 2020 (dated 25 March 2020) showed a worsening picture with the initial peak need by 13 April 2020 increased to 17,516 ventilators.[150] The second peak by 5 June 2020 remained similar at 15,448 ventilators.

4.73. On this estimate, the NHS would have run out of ventilators on 13 April 2020. It was recognised that it would not be possible to obtain the additional ventilators required

[145] GRW/141 - [GWI_INQ000513012]
[146] GRW/142 - [INQ000512997]
[147] The 9:15 meetings are described above at paragraph 1.7
[148] GRW/143 - [INQ000056105]
[149] GRW/144 - [INQ000056260]
[150] GRW/145 - [INQ000478787]

via the Ventilator Challenge by this date. However, there were predicted to be subsequent peaks and the goal was to reduce, and ultimately eradicate, any shortfall of ventilators as soon as possible.

4.74. On 27 March 2020, a summary of the process and outcome of the initial TDA review and status of the suppliers and products included in the Ventilator Challenge at that stage was presented to the COVID-19 Strategy Ministerial Group Meeting.[151] At this meeting, the Prime Minister stated that every lever Government had at its disposal should be utilised to achieve the required 8,000 ventilators by 13 April 2020.[152]

4.75. Following the update on 26 March 2020, the Cabinet Office was not provided with any updated forecasts on the need for ventilators for a couple of weeks.

4.76. On 30 March 2020, a Ventilator Ministerial Briefing was given on the projected ventilator capacity and the steps which were being taken to address the projected shortfall, including the Ventilator Challenge.[153]

4.77. As the projects with the 16 selected suppliers/devices progressed, there was a cutting down process as the least promising projects were stopped when it became clear they would not be successful, either in design or in rapid manufacture.

4.78. The targets for ventilators did not impact how quickly projects were stopped because it was not known at that stage how many would generate viable designs/products. Projects were stopped as quickly as possible once it was known that a design would not meet the clinical requirements established by the RMVS as assessed by the TDA. The projects were stopped to limit the cost impact and the distraction of running excess projects.

4.79. Letters were written to suppliers informing them when their project was stopped. There were also individual meetings with each stopped supplier to provide support and feedback.

4.80. The two key considerations in deciding which projects/suppliers to stop and which to continue to work with were:

4.80.1. Whether the design worked medically, so that it could be approved by the MHRA supported by the testing team, and accepted by clinicians. This was the most important factor.

[151] GRW/111 - [INQ000088311]; the presentation is at GRW/112 - [INQ000512989]
[152] GRW/146 - [INQ000088602]
[153] GRW/147 - [INQ000088318]

4.80.2. Whether sufficient volume of the design could be produced, under appropriate conditions to the required quantity standards and in time. The view was taken that some suppliers could not achieve the required scaling up and others could not do so in time.

4.80.3. The TDA thus assessed the regulatory, scalability and supply chain risk in each design before a manufacturing contract was entered into. If it was assessed that a design presented too much risk then the project team supporting that design was stood down. These decisions were minuted in the TDA meetings.

4.81. As the ventilators were to be used to push air into the lungs of unconscious patients, it was incredibly important that the ventilators were clinically safe. For example, if any contamination entered the ventilators it would be pushed straight into a patient's lungs, with potentially fatal consequences. Similarly, the ventilator performance had to be predictable under a variety of conditions, and the design and manufacturing process sufficiently reliable to ensure continuous operation for several weeks.

4.82. Some products failed to pass the medical suitability assessments or show a viable route to meet the RMVS Specification. Some products were unable to source the components required in time for planned manufacture.

4.83. The Cabinet Office attended the TDA Meetings at which the decisions on medical suitability, effectiveness, ability to achieve MHRA approval and manufacturability (including suitability for volume production, availability of components, robustness of supply chain) were made. The TDA carried out multiple rounds of assessment of each ventilator.

4.84. The Cabinet Office team working with each supplier would collect the relevant information about the project and send it to the TDA. Professor Tom Clutton-Brock and his testing team would also provide their views on each ventilator by way of written reports.[154]

4.85. Initially, given the lockdown measures, the testing team reviewed the ventilators across video conferences with the suppliers, in which they demonstrated their prototypes or products to identify problems or required changes.

[154] GRW/148 - [INQ000497233], GRW/149 - [INQ000497231], GRW/150 - [INQ000497234], GRW/151 - [INQ000497232], GRW/152- [INQ000497236], GRW/153 - [INQ000497237], GRW/154 - [INQ000497235], GRW/155 - [INQ000497226], GRW/ X - [INQ000497238], GRW/ X - [INQ000497230], GRW/ X - [INQ000497241], GRW/156 - [INQ000497239], GRW/160 - [INQ000497225], GRW/161 - [INQ000497240]

4.86. Eventually, each supplier had to send a ventilator to the testing team to test. The testing team had beds with dummies and operated the ventilators on the dummies for a prolonged period (at least 24 hours continuous use) to see if they were safe and medically compliant. Professor Clutton-Brock built more test rigs to facilitate this testing.

4.87. If the testing identified a fundamental problem then the advice from the testing team to the TDA would be that the project should be stopped. In some cases this was because there was insufficient time to fully test the software (in on-board microprocessors) such that the device's performance could be guaranteed. If the testing team considered that there was an issue but it could be changed on the back of coaching from the testing team, its advice would be that the project could be retained until the next meeting of the TDA.

4.88. The supply chain analysis of designs was a key part of identifying which ventilator designs were suitable for volume manufacture.[155]

4.89. The costs of the different suppliers were not a consideration in the decisions on which suppliers to stop or proceed with. However:

4.89.1. The Cabinet Office team was keeping track of the costs incurred and the forecast costs in a financial spreadsheet (see paragraph 4.134 for further information). This spreadsheet was maintained by PA Consulting who sent regular (at least weekly) updated versions to Dan Webster (including during the closing activities). This spreadsheet was used to brief Ministers.

4.89.2. The Cabinet Office had a ROM (Rough Order of Magnitude) cost based on the market price for ventilators (as of March 2020).[156]

4.89.3. As explained in paragraph 4.57 above, a commercial lead (a GCF staff member with relevant commercial training and accreditation) from the Ventilator Challenge team had been assigned to each supplier, who had control over and had to approve all commercial activity with each supplier, with oversight from a senior civil servant and the SRO.

4.89.4. There were overall financial controls on the spending of the Ventilator Challenge programme as explained below.

[155] Summaries of this analysis can be found in TDA documentation, for example GRW/162 - [INQ000513000] and GRW/163 - [INQ000496907] (page 14)
[156] GRW/82 - [INQ000497221]

4.89.5. Generally, the intent of most suppliers involved in the Ventilator Challenge was to cover their costs. The design teams were engaged on the basis that the Cabinet Office would cover their reasonable and evidenced costs, including time and materials manpower rates agreed in the contracts. Penlon and Smiths Medical were engaged on the basis of paying their open book costs plus an allowable profit margin consistent with historic profit levels,[157] and Breas were paid a previously agreed "NHS" price from an existing framework agreement.

4.89.6. The MoD's CAAS team carried out financial due diligence on selected suppliers, providing Supplier Insights Reports on the initial list of suppliers sifted from the "call to arms". CAAS undertook further financial checks for suppliers at different stages of the process from pre-contract costs through to invoice checks and wind down activity, based on TDA decisions and outcomes.[158] For example, between April and May 2020, pre-contract checks were undertaken for Renishaw, Airbus, Meggitt, Smiths Consortium, Ultra, Thales, McLaren, BlueSky Consortium, PA Design and Cambridge Consultants. This was particularly important given that the Cabinet Office made a number of advances to suppliers to cover materials and other costs (see paragraph 4.64).

4.89.7. The commercial leads undertook a final review of costs (and product status) before any formal contract was placed to purchase ventilators.[159]

The Technical Design Authority (TDA)

4.90. A further TDA review took place on 6 April 2020.[160] No previously selected projects were stopped at this stage. Seven new potential suppliers were subject to an initial review.[161]

4.91. At TDA sessions held on 9 and 10 April 2020, it was decided to stop support for the Helix, Blue Sky and OxVent devices subject to confirmation that this view was appropriate following testing.[162]

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[157] 15% agreed for Penlon (see GRW/164 - INQ000497249) and Smiths (see 'Model 5k' sheet, column J rows 1-6, in GRW/165 - INQ000497248)
[158] GRW/87 - [INQ000477277] - see pages 8-9, GRW/166 - [INQ000496728], GRW/134 - INQ000478819].
[159] See GRW/167 - [INQ000497228] and GRW/168 - [INQ000497227] for examples of the summaries provided by commercial managers to the SRO for approval of the contracts.
[160] GRW/169 - [INQ000501921]
[161] GRW/142 - [INQ000512997]
[162] GRW/170 - [INQ000478797]

4.92. On 10 April 2020 the MHRA's RMVS Specification changed substantially. In particular, it was identified that the ventilators needed to be able to treat acute respiratory distress syndrome (ARDS). Ventilators needed frequently to be able to remove fluid from lungs which were full of mucus, and in addition have sufficient pressure to overcome the higher resistance that was encountered. As a result of this change a number of projects were stopped following the TDA on 10 April 2020.[163] For example, the Emergency Ventilator Apparatus (EVA) device was stopped. 15,000 of the EVA devices were about to be assembled by Plexus, with most of the components already sourced or manufactured. This ventilator was being developed by TEAM Consulting based on an existing device (not licensed in the UK) supplied by Diamedica. This device helped the breathing of patients under a general anaesthetic for operations. However, it was identified that the EVA devices had sufficient power to provide ventilation for those with healthy lungs, but did not have enough power for those with ARDS.

4.93. This significant shift in the RMVS Specification and the approach of the Ventilator Challenge was driven by two factors (as explained at the TDA on 14 April 2020[164] and in the TDA's review published on 15 April 2020[165]):

4.93.1. First, the forecast demand for ventilators was lower and increasing at a slower rate than the initial forecasts (that suggested that patient demand was set to significantly outstrip supply).

4.93.2. Second, the understanding of the clinical requirements of ventilators to treat patients with COVID-19 had increased, including (i) requiring sufficient pressure to address ARDS as above, (ii) having a spontaneous breathing mode because patients were spending longer in a lightly sedated phase in which they made some but inadequate breathing efforts and (iii) the regular suction required for COVID-19 patients on a ventilator to remove the volume of secretion in their lungs, which required the pressure supplied by the ventilator to rapidly adjust.

4.94. As a result of these changes, there was less merit in continuing to develop less capable devices and more time to deliver ventilators which would suit the longer term needs, including the risk of a further peak in winter 2020.[166]

[163] GRW/171 - [INQ000512993]
[164] GRW/172 - [INQ000478006], GRW/173 - [INQ000501925]
[165] GRW/174 - [INQ000478830]
[166] GRW/171 - [INQ000512993]

4.95. This was summarised in an email that I sent to Lord Agnew on 10 April 2020. In this I pointed out that "Today's CRIP shows a short-term target of some 6,000 (ventilators)".[167] The Commonly Recognised Information Picture (or CRIP) is a daily situation report produced by the Civil Contingencies Secretariat. This target was radically lower than previous targets set by DHSC and NHS E&I. It justified a strategy of reducing the number of parallel designs being taken forward to concentrate resources on those closest to volume manufacture.

4.96. On 11 April 2020, a submission was made to the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office and Lord Agnew formally updating them on the progress and decisions taken in the first weeks of the Ventilator Challenge up to 8 April 2020.[168]

4.97. On 12 April 2020, a further submission was made to the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office and Lord Agnew.[169] This submission identified that (1) new clinical evidence suggested that ventilators for COVID-19 patients required suction and spontaneous breathing, and (2) there was a reduced demand for ventilators. A recommendation was made asking for confirmation that the Ventilator Challenge should change its targets so that it would produce 18,000 ventilators by the end of April and 30,000 ventilators by the Summer.

4.98. Following a further TDA session on 14 April 2020, it was recommended that work on the OxVent and Invicto projects was stopped.[170] It was recommended to continue with the manufacture and purchase of 5 devices.[171] These included the LTV2 by Vyaire, a product that was potentially going to be scaled up in the USA (which did not receive any funding because it was unclear if it was ever going to be scaled up, and importantly, even if it was, whether it would be CE marked, something by this stage that was needed), Breas Medical's two devices, the Smiths ParaPac and the Penlon Prima ESO2. The other 9 devices were to be subjected to further testing as to their capability and suitability.

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[167] GRW/175 - [GWI_INQ000512992]
[168] GRW/176 - [INQ000513010]
[169] GRW/177 - [INQ000477252]
[170] GRW/172 - [INQ000478006], GRW/173 - [INQ000501925] Note: This statement originally stated that work stopped on OxVent, Invicto and Blue Sky projects. Further review of the evidence identified that Blue Sky had already stopped and it was recommended, rather than decided, that work on OxVent and Invicto projects be stopped. Please see a full explanation of this correction in footnote 298 of Cabinet Office the corporate statement dated 20 December 2024 [INQ000528389]
[171] GRW/173 - [INQ000501925]

4.99. On 15 April 2020, in response to the submission made on 12 April 2020, Lord Agnew (Minister of State for the Cabinet Office) had a meeting with Michael Gove (Chancellor of the Duchy of Lancaster & Minister for the Cabinet Office) and Edward Argar (Minister of State for the Department of Health and Social Care) to seek to understand the number of ventilators required. At this meeting a total target for mechanical ventilators – comprising (i) existing NHS ventilators, (ii) procurement of existing ventilators led by the DHSC and (iii) the Ventilator Challenge – was agreed of c.30,000 mechanical ventilators by the end of June 2020.[172] It was further agreed at this meeting to prioritise the manufacture and purchase of the 5 devices referred to in paragraph 4.98 plus the OES Medical device.

4.100. By this stage, it had been identified that the NHS had already around 8,000 ventilators in service.[173] Additionally, around a further 1,000 ventilators had been found by contacting veterinary surgeries.

4.101. DHSC produced and circulated a daily spreadsheet showing the number of ventilators which DHSC expected to be able to procure from existing suppliers.[174] While this number fluctuated, it was used by the Ventilator Challenge to identify the "balancing number" it needed to obtain in order to meet the overall 30,000 target. These figures were then used in the information packs provided for the daily meeting with Lord Agnew.[175]

4.102. On 17 April 2020, Vyaire presented its LTV2 device to a panel of clinicians from the TDA. Pre-pandemic, this device was only in use in Japan and was not CE marked. The LTV2 was regarded as suitable for long term use in the UK, however Vyaire needed to send a machine to Professor Tom Clutton-Brock to test and provide its plan to obtain CE marking (so that the ventilators could be used beyond the end of the pandemic and the period of emergency derogations granted by the MHRA).[176]

4.103. The TDA on 22 April 2020[177] recommended that the following devices should remain in the Ventilator Challenge and preparations made for manufacture:

4.103.1. Nippy 4+ and Vivo 65 by Breas Medical.

4.103.2. The Prima ESO2 by Penlon.

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[172] GRW/178 - [INQ000421253], GRW/179 - [INQ000477255]
[173] GRW/180 - [INQ000477237]
[174] See for example GRW/181 - [INQ000478805]
[175] See for example GRW/76 - [INQ000513011]
[176] GRW/182 - [INQ000478807]
[177] GRW/183 - [INQ000513002]

4.103.3. The ParaPac by Smiths.

4.104. The TDA also recommended that other devices should remain in the Ventilator Challenge, with further development funded, but this position should be reviewed at a later date. Finally, the TDA recommended that a number of devices should be removed from the Ventilator Challenge.

4.105. The devices which the TDA recommended should be removed included the Mosquito by Sagentia. The technical file for this device was only submitted to the MHRA after 10pm on 20 April 2020, meaning there was no time for the appropriate review and collation of this information before the TDA on 22 April 2020. A further TDA session was held on 30 April 2020 to review the technical file on the Sagentia device.[178] However, this information did not change the recommendation to remove Sagentia from the Ventilator Challenge.

4.106. On 23 April 2020, following the recommendations from the TDA, a submission was made to the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office and Lord Agnew to decide which suppliers to proceed with and which should be removed from the Ventilator Challenge.[179] On 24 April 2020, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office and Lord Agnew decided to remove the least clinically viable products according to MHRA and the TDA's testing team.[180] As well as proceeding with the Smiths Medical, Penlon and Breas devices, it was decided to continue to support the other designs for a further week, with additional funding of up to £250,000, ending on 4 May 2020. The devices which received this support were PiranVent by Swagelok, Veloci-Vent by Cambridge Consultants, CoVent by Dyson, Mosquito by Sagentia and Florence by BAES. These projects were primarily extended to allow the supply chain visibility of the Penlon and Smiths devices to improve before a final decision was made. The short extensions also provided some phase out for these products and the (small) possibility for the Veloci-Vent in particular to pass testing.

4.107. On 29 April 2020, there was a TDA review on whether to recommend investment into a Closed-Circuit Rebreather CPAP (3CPAP) device.[181] The TDA recommended

[178] GRW/184 - [INQ000478806]
[179] GRW/185 - [INQ000512994]
[180] GRW/186 - [INQ000471010] Note: this readout incorrectly states that the least clinically viable products to be cut were "the Gemini, the Zephyr, the Oxvent and the Florence". As is clarified in the subsequent Cabinet Office corporate statement, those which were cut were the EVA by Team Cogent, the Helix by Plexus, the OxVent and the InVicto by JFD. See paragraph 5.27-5.28 of that statement [INQ000528389], dated 20 December 2024
[181] GRW/187 - **[INQ000505976]**

that there was a need for devices that could conserve oxygen in the NHS but further information was required before any recommendations could be made. A Closed-Circuit Rebreather design by Vobster had been supported by the Ventilator Challenge, however the NHS solved the oxygen shortage issue.

4.108. On 5 May 2020, there was a further TDA review of the five designs for which support had been extended for a further week (see paragraph 4.106 above).[182]

4.109. Following this meeting of the TDA, on 7 May 2020 a submission was made to the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office Michael Gove, and Lord Agnew, recommending that support for all five of these suppliers should be stopped because (1) these devices did not meet the current clinical need (albeit some were very close), (2) these devices would not receive emergency exemption use from the MHRA, and (3) the Ventilator Challenge was already forecast to achieve the target of 30,000 stock of ventilators by the end of June 2020 without these devices.[183] These recommendations were accepted.

4.110. A further TDA was held on 21 May 2020 to rank, in terms of clinical utility, the devices in the Ventilator Challenge, including a specific comparison of the Gemini and Zephyr+ devices.[184]

4.111. By 29 May 2020, Lord Agnew informed Edward Argar (Minister of State at the Department of Health and Social Care) that the Cabinet Office predictions were that the Ventilator Challenge would need to account for 18,000 of the 30,000 target.[185]

4.112. In response, on 9 June 2020, Edward Argar (Minister of State at the Department of Health and Social Care), on account of the successful measures taken to suppress COVID-19 (and thus reduce the peak demand for ventilators) such as social distancing, reduced the target for the Ventilator Challenge to 13,000 ventilators.[186]

Devolved Administrations

4.113. The Ventilator Challenge produced ventilators for the four nations of the UK and the overseas territories. The allocation and distribution of the ventilators was the responsibility of DHSC. DHSC operated a loan-based approach whereby ventilators were supplied to the devolved administrations and NHS trusts, and then returned

[182] GRW/188 - [INQ000512998], GRW/189 - [INQ000513005], GRW/190 - [INQ000513001], GRW/162 - [INQ000513000]
[183] GRW/191 - [INQ000512999]
[184] GRW/192 - [INQ000480125]
[185] GRW/179 - [INQ000477255]
[186] GRW/193 - [INQ000477935]

following the pandemic. Ventilators from the Ventilator Challenge were fed into this distribution process.

4.114. Members of the Ventilator Challenge engaged with Scottish Enterprise as part of sourcing manufacturing parts. On 9 April 2020, Lord Agnew met with Ivan McKee, Scotland's Minister for Trade, Investment and Innovation, to discuss the Ventilator Challenge.[187]

Ventilators purchased

4.115. Initially, development contracts were deliberately placed for several designs to ensure that there was not an over-reliance on a single device (in the event that a device failed to pass the MHRA tests, failed in practice or the manufacturing capacity could not be stood up, for example due to a shortage of key components). By the time the field had been narrowed by the TDA process, confidence had grown about the functionality of the remaining designs, although the risks inherent in scaling up manufacturing were still present. The intention at this stage was to obtain the highest functionality possible and also to have a balance of functionality between transport ventilators and hospital ventilators.

4.116. The Cabinet Office awarded contracts to purchase three different ventilators from two different suppliers:

4.116.1. Two separate contracts were awarded to Penlon:

- The first contract was entered on 26 March 2020 for 5,000 Prima ES02 ventilators with a contract value of £30,770,000 (excluding VAT).
- The second was entered on 29 March 2020[188] for a further 10,000 Prima ES02 ventilators with a contract value of £105,230,000 (excluding VAT).

4.116.2. Two contracts were awarded to Smiths Medical:

- A contract was entered on 29 May 2020 for 4,418 ParaPac 300 ventilators, with a contract value of £34,007,542.

[187] GRW/194 - [INQ000496706], GRW/195 - [INQ000496707]
[188] Note: this date has been corrected. It was originally stated as '7 June 2020'. Please also see footnote 309 of the Cabinet Office corporate statement dated 20 December 2024 [INQ000528389]

- A contract was entered on 2 July 2020 for 504 ParaPac plus 310 ventilators, with a contract value of £1,793,373. The ParaPac 310 is an enhanced variant of the 300 model.

4.116.3. A fifth contract was entered into by DHSC with Breas Medical by a purchase order dated 1 April 2020.[189] DHSC entered this contract, not the Cabinet Office, because it was a call-off under an existing DHSC framework.

4.116.4. The Government Legal Department developed contracts for Smiths Medical and Penlon. As stated above, ventilators were purchased from Breas through DHSC using the terms of the pre-existing NHS framework, together with a separate agreement to establish a second production line at the Breas factory in Sweden to produce the additional volume needed for the NHS (see 4.128.1 below).

4.117. Breas Medical's price was cheaper, because it was an existing design whose price had been agreed as part of a pre-existing framework agreement. More ventilators were not purchased from Breas Medical because it was not possible to manufacture them in the time available. Breas Medical was also supplying ventilators to other governments/countries.

4.118. Each device was subject to extensive final testing in hospitals to ensure they were safe and effective before being authorised by the MHRA and formal contracts placed for mass supplies.

4.119. These contracts were awarded under the negotiated procedure without prior publication (commonly referred to as direct award) on the grounds of extreme urgency brought about by events unforeseeable for the contracting authority which meant the time limits for a competitive process could not be complied with in accordance with Regulation 32(2)(c) of the 2015 Regulations.

4.120. Contract Award Notices were published on 21 May 2020,[190] 24 August 2020[191] and 31 December 2020[192] in respect of the 29 Ventilator Challenge contracts to a range of suppliers and designers including the 5 contracts referred to in paragraphs 4.116 above. Corresponding Contracts Finder Notices were published on 27 May 2020,[193]

[189] GRW/138 - [INQ000497269] - see column I, row 13.
[190] GRW/196 - [INQ000477285]
[191] GRW/197 - [INQ000471054]
[192] GRW/198 - [INQ000471053]
[193] GRW/199- [INQ000477284]

27 August 2020[194] and 11 January 2021[195] in relation to the 29 contracts, but the contracts themselves were not published. Both the Contract Award Notices and the Contracts Finder Notices included justifications for reliance on Regulation 32.

4.121. The justification for the use of direct awards was also included in the Regulation 84 report issued in June 2020.[196]

4.122. In early February 2023, some oversights were identified in terms of compliance with publication obligations. Therefore, the Cabinet Office:

4.122.1. updated the Contracts Finder Notices referred to in paragraph 4.120 to include the required copies of the contracts themselves;[197]

4.122.2. issued further Contract Award Notices in respect of those referred to in paragraph 4.120 to reflect actual spend under those initial 2020 Contract Award Notices and further spend in respect of the four contracts entered by the Cabinet Office referred to in paragraph 4.116 above;[198] and

4.122.3. issued Contracts Finder Notices and copies of contracts in respect of an additional three call off contracts from a CCS framework and one below threshold contract.[199]

4.123. These contracts were awarded by the Cabinet Office on different financial terms:

4.123.1. Smiths Medical and Penlon were engaged on a cost plus mark-up basis.[200]

4.123.2. Breas Medical, as an existing supplier of ventilators to the NHS, was engaged via a DHSC framework at the framework price, save that the Cabinet Office also paid to set up a new production line in Sweden required to deliver the capacity. Breas was already commissioning one product line to make the new products. We asked Breas to commission a second line and dedicate it to our orders. This line was set up in

[194] GRW/200 - [INQ000477286]
[195] GRW/201 - [INQ000477287]
[196] GRW/87 - [INQ000477277]
[197] GRW/202 - [INQ000409844] provides the full list of Contract Finder Notices.
[198] 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').
[199] See GRW/202 - [INQ000409844] for information on contracts with Quo Imus Ltd, BSI Group International Ltd, Mills & Reeve LLP and Same Day PLC Guardian Service.
[200] See GRW/164 - [INQ000497249] for Penlon invoice example and see 'Model 5k' sheet in GRW/165 - [INQ000497248] for example of the Smiths mark-up.

Sweden because Breas Medical had accredited facilities in Sweden which were ready for manufacture.

4.124. Each contract, and the price, was also subject to compliance with the delivery schedule.

4.125. Ultimately, the following ventilators were provided to the NHS:

Device	Designer	Manufacturer	Number received by the NHS	Cost (inc. VAT)	Cost / Device
Prima ES02	Penlon	HVM Catapult (Ford, Siemens, McLaren, others)	11,683	£125.8m	c.£11,000
ParaPac 300 & 310	Smiths Medical International	GKN/ Rolls Royce	1,392[201]	£26.6m	c.£19,000
Nippy4+	Breas Medical	N/A	1,000	£9.6m	c.£4,800
Vivo65	Breas Medical	N/A	1,000		
Totals			**15,075**	**£160.6m**	

4.126. All four of these ventilators are CE marked, meaning they are available for use by the NHS beyond the duration of the Pandemic.

4.127. There was an additional project to upgrade the Penlon Prima ES02 ventilators from September 2020. The upgrade was to increase the functionality of the Penlon ventilators so that they could detect when a patient was starting to wake up and attempt to breathe for themselves. Without this functionality, patients would have needed to be switched to a different ventilator when waking up or be carefully monitored by a doctor to adjust the ventilation to match the changing breathing

[201] Smiths Medical and its project partners were unable to successfully scale up its manufacturing to deliver the agreed volume of Parapac 300 ventilators in the required time frames. The number of ventilators purchased from Smiths Medical and the contract value for its first contract were therefore reduced.

patterns. The cost of this upgrade was included in the overall spend of the Ventilator Challenge (see below).

4.128. In practice, each supplier posed different challenges or issues which the Ventilator Challenge team was tasked with addressing and overcoming. Taking the three suppliers with whom formal contracts were ultimately entered for the supply of ventilators as examples:

4.128.1. Breas Medical had a new but complete design which it was about to launch. No one else had yet ordered this new product. The blocker was its limited manufacturing capacity and the risk of exports being stopped, but Sweden, where Breas Medical was based, did not do so. As explained in paragraph 4.123.2, the Ventilator Challenge team assisted in setting up and then paid for a second production line in Sweden dedicated for UK use, including providing the necessary start-up costs. It was desirable to set up this line within the existing Breas facility because that facility already had the necessary regulatory approvals and quality certification to make medical devices. More devices were not ordered from Breas Medical because its view was that it would not be able to obtain the necessary components to set up more parallel production lines.

4.128.2. Smiths Medical International Ltd **(**"Smiths Medical"**)** had an existing product, the Parapac, which was a portable ventilator used in ambulances, by paramedics and when moving patients around hospitals. These ventilators would not be used for primary or prolonged care in hospitals, but it was decided that it was worthwhile to obtain more. The challenge was to scale up the manufacturing capacity of the Parapac design. Smiths worked with GKN and Rolls Royce. Ultimately, the scale up was not as successful as hoped so relatively fewer of these devices than planned were purchased. The money saved was used to upgrade the Penlon ventilators which had already been purchased, as explained above.

4.128.3. In contrast, Penlon had a small manufacturing capacity, capable of a maximum of 50 units a week, but its existing design/product was a machine used to help patients breathe while they were under general anaesthetic, not a ventilator. The challenge was to help to adapt the anaesthetic machine into a full mechanical ventilator. Fortunately the

Penlon product range was modular and a new device was put together using modules from other units. Their major challenge, apart from capacity, was to obtain the necessary components. For example, the CPUs had been produced in California but production had stopped 10 years before. It was necessary to arrange for the chip production line in California to be restarted. The valves also had to be purchased from Switzerland, while the only supply of the screens was found to be a surplus website in China. A detailed Bill of Materials was completed by 26 March 2020, with McLaren, Ford and Arrow engaged to identify, reverse engineer and manufacture other at-risk components.[202]

4.129. Once the ventilators were delivered to the distribution centre, the DHSC decided where and to whom they were to be delivered. The Cabinet Office was not involved in this process.

4.130. I understand from NHS England's public statements that even at the height of the pandemic there was no shortage of ventilators and intensive care, and the Ventilator Challenge will have played a role in that.[203]

4.131. The usage of the ventilators was less than predicted for a variety of factors including:

4.131.1. The impact of the lockdowns, which slowed the increase in the number of patients with COVID-19 and who required ventilators.

4.131.2. Clinical progress in treating patients with COVID-19 including treatments for ARDS and non-invasive methods of giving oxygen.

Other suppliers who developed viable products

4.132. The Ventilator Challenge projects for four other suppliers were successful in that their ventilators were deemed clinically viable, namely: (i) the Zephyr+ by Draeger/Babcock, (ii) the Gemini by OES Medical, (iii) the Piran Vent by Swagelok and (iv) the Veloci-Vent by Cambridge Consultants Limited. However, no contracts were placed for these devices because by the time the designs were viable, the demand for ventilators in the NHS was lower than initially predicted and this demand was likely to be met by those mentioned in paragraph 4.116.

[202] GRW/112 - [INQ000512989], GRW/203 - [INQ000497247], GRW/204 - [INQ000497246]
[203] GRW/27 - [INQ000496764]

4.133. The reasonable costs for all suppliers with whom we did not proceed were paid (either on a cost or cost plus basis). A team from CAAS from the MoD audited the costs. While the design partner, TTP, did have its costs paid, Dyson asked not to be paid for its work and agreed to write off its costs.

Total spend

4.134. As explained above, all costs incurred by the Ventilator Challenge were recorded on a financial spreadsheet maintained by PA Consulting. The final version of the spreadsheet is exhibited to this statement.[204]

4.135. The total spend, including values recovered, was £301,948,077 including VAT (275,475,483 excluding VAT), for around 15,200 ventilators. This means that on average the ventilators produced by the Ventilator Challenge cost around £18,100 (excluding VAT) each. The total spent was just over £150m less than the delegated envelope granted by the Chief Secretary to the Treasury ("CST"), Steve Barclay MP (see below).

4.136. We understand that DHSC spent around £292 million excluding VAT on their ventilator programme, including on buying ventilators and other oxygen therapy devices and on programme administration, storage and logistics costs. This included £244 million for around 11,100 mechanical ventilators of all types at an average cost of around £21,900 (excluding VAT) per ventilator.

Financial controls

4.137. The Treasury approved the spending of the Ventilator Challenge within a set financial envelope.

4.138. On 20 March 2020, the CST, granted a delegated envelope to the Cabinet Office of £15m to spend on the Ventilator Challenge to cover the initial contracts with the design consultants.[205] The approval of a delegated envelope was an exceptional step which meant each contract did not need to be approved by the CST.

4.139. On 27 March 2020, the CST approved an increased delegated envelope spending up to £163m for the Ventilator Challenge to cover the first manufacturing contracts.

[204] GRW/205 - [INQ000513018]
[205] GRW/206 - [INQ000480114]

4.140. On 3 April 2020, the CST approved a delegated envelope of an additional £276m for the Ventilator Challenge.[206] Spending on the Ventilator Challenge had to be within this envelope (or Capital Departmental Expenditure Limit) or further approval would be required from the Treasury.

4.141. The CST set further conditions on the approval of the above expenditure "to ensure as robust a procurement process as possible is being followed in the time allowed".[207] The conditions were summarised in the letter from the CST to Secretary of State for Health and Social Care and the Chancellor of the Duchy of Lancaster and Minister of State for Cabinet Office on 24 April 2020.[208]

Indemnities

4.142. The accelerated design, regulatory review and approval and manufacturing of the ventilators meant that the Ventilator Challenge was able to achieve in a few months what normally could take over four years to do.

4.143. The manufacturers of components in the different designs and suppliers raised the question of liability if one of the ventilators caused the death of a patient.

4.144. In order to avoid delays to the manufacture and production of the ventilators, and given the confidence that the rigorous testing and clinical review carried out as part of the Ventilator Challenge would ensure that any designs which were produced were safe and the extensive quality assurance down the supply chain, the Cabinet Office agreed to provide indemnities to manufacturers that so long as they followed the designs they had been provided, the Cabinet Office would take the risk of any liability from a flaw in the design.

4.145. The indemnities were provided to designers and covered potential infringements of third-party IP rights. There was considered to be a low risk that there would be a claim on the indemnities. A departmental Minute was presented by the Cabinet Office to Parliament explaining these indemnities.[209] The indemnities were approved by the Treasury. So far, no claims have been made under the indemnities.

[206] GRW/206 - [INQ000480114]
[207] GRW/206 - [INQ000480114]
[208] GRW/207 - [INQ000512995]
[209] GRW/208 - [INQ000471012], GRW/209 - [INQ000471015]

Close down

4.146. The Ventilator Challenge was closed down in June and July 2020. A Wrap Up Board was established which held meetings in June and July.[210]

4.147. The remaining activities and the documentation were handed over to DHSC. Assets were transferred to DHSC, but the Cabinet Office remained the counterparty to the contracts entered into in relation to the Ventilator Challenge (and therefore liable under the indemnities).

4.148. As part of the closing down, PA Consulting carried out an exercise of disposing of unused components that had been bought. This scrappage programme (selling components which were no longer required as scrap or to suppliers) was started early on to maximise recovery of costs. This activity was reported in the daily pack and the sums recovered were recorded in the updates to the financial spreadsheet (see paragraph 4.134).

4.149. Through this exercise, the Ventilator Challenge recovered £36,412,989 (as set out for the "Value recovered" figure on the "Product Summary" tab of the financial spreadsheet).[211]

4.150. In June 2020, a "scrapbook" was produced with photographs showing the different ventilators designed and produced during the Ventilator Challenge.[212]

4.151. The Ventilator Challenge team in Cabinet Office reflected on lessons from the programme and fed into broader exercises: for example, a commission from No.10 explained at para 6.12, the NAO report on Ventilator procurement and Boardman 2 (see section F for further detail).

4.152. Other less formal "lessons learned" were captured in a document by PA Consulting on resourcing, set up/onboarding, supplier triage process and TDA delivery/management.[213] In addition a presentation was given to the Infrastructure and Projects Authority in June 2021 on the lessons learned from the programme.[214]

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[210] GRW/210 - [INQ000480127], GRW/211 - [INQ000478814], GRW/212 - [INQ000478817], GRW/213 - [INQ000513009], GRW/214 - [INQ000477937]
[211] GRW/205 - [INQ000513018]
[212] GRW/215 - [INQ000513008]
[213] GRW/104 - [INQ000496727]
[214] GRW/216 - [INQ000496736]

ii) Testing Equipment and Supplies

4.153. There was a clear and obvious need to test for COVID-19 from the earliest days of the pandemic; to identify patients that needed isolation and treatment, to screen healthcare workers and others that worked with vulnerable people, and to produce statistics that would allow decision makers to understand the prevalence and progress of the disease in the UK population. This need for testing soon outstripped the capacity of existing systems to deliver and these systems were not capable of the rapid scale-up needed to meet growing demand (as explained in paragraph 4.157 below). In addition there was pressure on the global supply of testing commodities as healthcare systems everywhere tested more and more people, and production was reduced as the pandemic affected suppliers. Increasing the UK capacity for testing needed the support of external agencies and industry, and this in turn drove the need for greater commercial capacity.

4.154. DHSC asked Lord Agnew and the GCCO for additional commercial support for testing on 18 March 2020. Dr Beverley Jandziol, a Deputy Director - Commercial Specialist (SCS1 level) from the Complex Transactions Team (CTT) - was assigned to support DHSC with immediate effect. Further CTT resources followed over the next few days which included two other Commercial Specialists (Pam Doyle and Tim Byford) and others to lead, design and deliver commercial activities to support testing scale up. Lucy Mason from the DHSC Commercial Directorate provided a valuable link into DHSC's commercial processes and governance. Many of these team members continued to work with DHSC on testing until late 2020. Some CTT support remained in place until March 2021 for knowledge transfer and to help transition to an expanded commercial directorate.

4.155. Working alongside colleagues from across government and external organisations, this GCF commercial team worked at pace to deliver a COVID-19 testing capability for the UK that met evolving Ministerial and Prime Ministerial targets.

4.156. This section of the statement focuses on some of the components involved in PCR testing and LFTs (as defined below) at the request of the Inquiry. The GCF, CTT and other parts of the Cabinet Office were involved in purchasing to support other areas of Test and Trace which were necessary in order to provide COVID-19 testing capability, some of which are mentioned in this section for context.

Introduction

4.157. It was essential to be able to test for the presence of the COVID-19 virus in order to treat patients effectively and understand the spread of the epidemic. At the beginning of the pandemic the UK's ability to test for COVID-19 was limited to NHS pathology labs, some PHE public health labs and a number of research facilities in universities or elsewhere. Estimated test capacity was circa. 6,000 tests per day,[215] but in practice an average of 3,000 tests per day were actually performed. It is important to note that theoretical testing capacity did not necessarily correlate to actual testing capacity particularly in the early days of the pandemic due to the lack of detailed oversight of the bill of materials, stock levels, resourcing availability and operating hours across the existing laboratory network which is devolved across NHS Trusts. This capacity did not readily lend itself to rapid expansion as it was in so many locations with limited opportunity to optimise capacity or industrialise and automate processes. There were circa 185 NHS laboratories grouped into 29 regional laboratory networks; 5 in London, 8 in Midlands, 8 in North, 8 in South; and PHE also had laboratories.

4.158. From the earliest stages of the pandemic, the importance of testing was recognised by the most senior levels of Government. On 14 March 2020, Imran Shafi, the Prime Minister's Private Secretary for public services (including healthcare), circulated information about a planned roundtable with diagnostic companies to discuss options for mass COVID-19 testing.[216] Some companies were invited at the suggestion of Will Warr, the Prime Minister's special advisor for Health, and others at the suggestion of a range of Government agencies as mentioned in Imran's email. The full list of attendees are recorded in the notes from the meeting produced on 17 March 2020.[217]

4.159. On 16 March 2020, actions from the 8.15am Daily Meeting included an action for Steve Oldfield (DHSC Chief Commercial Officer (CCO)) to convene a meeting with PHE and the Chief Medical Officer to discuss the strategy for testing, including how to procure and deploy testing equipment.[218] An earlier meeting on 14 March 2020 chaired by the Chancellor of the Duchy of Lancaster had explored ways that the

[215] GRW/217 - [INQ000478828]
[216] GRW/218 - [INQ000471002], GRW/X - [INQ000477904]
[217] GRW/219 - [INQ000478783]
[218] GRW/220 - [INQ000471003]

Cabinet Office could help the DHSC, including using commercial expertise to assist with procurement for testing.[219]

4.160. Testing is a complex technical field requiring equally complex procurement activity. In the period of interest to the Inquiry, government Departments, (primarily DHSC and its ALBs), purchased a very wide range of consumables,[220] equipment, logistics, infrastructure and services, to support numerous testing methods. Some of these products were only invented and developed at speed during the pandemic, as while the underlying technologies (PCR, LAMP, LFT) were in existence, new assays specific to COVID-19 needed to be developed. As a result of this, and because of the volumes required to meet demand, it was necessary to develop the capacity and capability of suppliers. Commercial decisions had to be taken on the basis of incomplete and emerging information. Other significant commercial challenges included:

4.160.1. The technical complexity of the products and equipment purchased,

4.160.2. Ensuring their compatibility with other products and equipment, and

4.160.3. Ensuring that specifications and standards were met .

4.161. Work to establish testing infrastructure commenced prior to the inception of Test & Trace, reaching a daily testing capacity of 100,000 tests per day by the end of April 2020.[221] When Test & Trace was established in May 2020, the agenda expanded to include the establishment of 'Trace' whilst further growing and diversifying testing capability in preparation for Winter 2020 and an anticipated increase in infections.

4.162. This part of the statement describes how the Cabinet Office supported DHSC, PHE and the NHS in building a national testing capacity. It also includes the steering and supporting role played by No.10, the enabling of spend through Cabinet Office controls and the deployment of a number of skilled commercial professionals to help manage and execute the critical work of buying equipment, supplies and services.

Types of Tests

4.163. I will now describe the different types of tests covered by this statement.

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[219] GRW/78 - [INQ000411831]
[220] Meaning a commodity intended to be used up quickly, such as laboratory chemicals and swabs.
[221] GRW/222 - [INQ000478800]

4.164. **Polymerase Chain Reaction (PCR) test.** A PCR test requires a swab from the test subject. These are usually taken by a healthcare provider (though as the pandemic progressed instructions were developed to enable self-collection of samples) and transported to a laboratory for testing. It may take a number of days to receive the results due to the time taken between sampling, transportation, laboratory processing, testing and processing of a result. When we refer to a PCR test generally, we are typically referring to an RT-PCR or RT-qPCR (reverse transcription polymerase chain reaction) test which was considered the 'gold standard' by scientists and was therefore most commonly used throughout the pandemic to test for presence of the virus. RT-PCR works by increasing (amplifying) the amount of viral DNA present so that it can be detected. Later in the pandemic, end point PCR or ePCR was introduced. Though still requiring a swab sample that is processed in a laboratory, ePCR follows a different protocol within the laboratory and provides less detailed results. An ePCR result confirms the presence or absence of the virus but does not provide as much quantitative detail as an RT-qPCR test. However, the protocol involved means tests can be conducted more quickly and at lower cost. RT-PCR detects both infectious and inactive viral genetic material (inactive due to the action of the immune system or death of the virus). This can lead to an overestimate of individuals with clinically significant detectable virus.

4.165. **Antibody tests**. These tests check for antibodies to see if the test subject has had an infection with the virus in the recent past - different tests can detect antibodies for different lengths of time after the infection took place. These tests are not used for diagnosis but rather to provide a better understanding of the prevalence of the virus in different places (for example in a regional survey). This test requires a blood sample, taken as a full sample for a laboratory test or using a finger prick device for a lateral flow antibody test.

4.166. **Lateral Flow Device (LFD) and Lateral Flow Test (LFT).** A LFD, also known as a LFT, is a fast and simple way to test people. They are easy to use and give results in under half an hour (exact time dependent on specific product). Typically, a lateral flow test has lower sensitivity than a laboratory based test (this means that it may miss some positive cases). There are 2 types of LFD or LFT:

4.166.1. **Lateral flow antibody test**. These tests require a blood sample via a finger prick device and the test checks for recent infection by the virus. These tests cannot be used for diagnosis.

4.166.2. **Lateral flow antigen test or rapid antigen test (also referred to as Antigen LFTs).** Lateral flow antigen tests are rapid turnaround virus tests that can process samples at the point of use, without the need for laboratory equipment. Most produce easy-to-understand results in under half an hour. The antigen test detects proteins in the virus (unlike PCR which detects genetic material). While LFTs may have high specificity on a par with PCR, they have significantly lower sensitivity (i.e. they are less likely to detect low viral loads).

4.167. **Reverse - transcription loop-mediated isothermal amplification (LAMP)**. Like a PCR test, a LAMP test looks for viral genetic material. Unlike PCR tests, LAMP tests do not require sequential changes of temperature and therefore can turnaround results more quickly than traditional PCR testing. However, using LAMP for viral testing was less common within the NHS due to issues relating to contamination risk between samples as it is a highly sensitive test if utilising the RNA extraction step. For a quicker turnaround time and reduced sensitivity "direct LAMP" can be used which excludes the need for RNA extraction. By April 2020 direct LAMP was being used as a rapid test to triage patients arriving at A&E in a Hampshire NHS Trust which led to it being piloted by DHSC in May 2020 to test its viability as a testing solution for differing clinical situations ("use cases").

4.168. **LamPORE.** LamPORE means 'Loop-mediated isothermal amplification and nanopore' sequencing to provide a highly scalable detection of COVID-19. This was highly mobile technology making it ideal for deployment in remote locations across various use cases.

Evolution of use of different testing methodologies

4.169. The 'Technical report on the COVID-19 pandemic in the UK'[222] (dated 1 December 2022) by the Chief Medical Officers (CMOs), Deputy CMOs, the Government Chief Scientific Adviser and the National Medical Director explains that: "Throughout the pandemic, the capacity and effectiveness of laboratory processing, delivery and distribution routes and global demand and supply of materials continually changed. Testing strategies were continually adapted in response, and as the epidemiology changed and wider pandemic strategies also adjusted (for example, where routine testing enabled strategies supporting the labour market). Testing strategies also evolved as new technologies became available and as evidence emerged on the

[222] GRW/223 - [INQ000177534]

potential needs, use cases and population responses to different testing options – such as self-testing, as opposed to that undertaken by a health professional or in clinical settings only, or accessibility of public testing centres. Testing evaluation initiatives were important throughout in understanding this and helped shape government policy".

4.170. At the beginning of the pandemic, RT-PCR was the gold standard of testing. It was the only widely recognised testing methodology for COVID-19 available. It was an established technology which gives a quantitative view of the amount of viral genetic material present in a sample. Tests generate a very small number of false negatives (high sensitivity) and equally a small number of false positives (high specificity). As an established and widely recognised testing methodology, initial focus on increasing testing capacity centred around the scale up of RT-PCR testing.

4.171. As the pandemic progressed, and in collaboration with suppliers, other amplification technologies that could detect presence of the virus (LAMP, LAMPore) were identified. These were quicker and cheaper, and some could be used at the point of care (rather than in a specialised laboratory) but were sometimes less sensitive depending on the adopted protocol (e.g. direct LAMP, RT-LAMP, LAMPore). As these technologies were less proven as a COVID-19 testing technology, work was done to validate the technologies and identify their use cases, in parallel to scaling up PCR testing capacity. As validation data became available, the testing programme (by then Test & Trace) was able to make decisions on where and how to deploy these additional technologies.

4.172. Alternative testing technologies such as LAMP and LAMPore were in some cases deployed to increase supply-chain resilience (reducing the need for e.g. consumables and equipment from overseas), to enable testing to be performed in a wider range of use cases and to increase the overall capacity of the testing system.

4.173. Lateral Flow Tests (LFTs) also use an established technology that has been used for a variety of medical purposes since the 1990s. Early in the pandemic antibody LFTs were offered to the Government. These antibody LFTs use a finger prick blood sample to detect if the test subject has previously been infected, and are useful for surveillance studies (to detect what proportion of a population had been exposed to COVID-19 - in the UK, for example, the REACT surveillance study[223]). From summer 2020 antigen LFTs became available in significant quantities. These detect

[223] GRW/224 - [INQ000472189]

the presence of the virus itself using material obtained via a nasopharyngeal swab[224] (which gets a sample from the nose and throat). While lower in sensitivity to RT-PCR tests, they are also cheaper and can be self-administered. Antigen LFTs, once validated, offered a route to mass testing of large groups of people, including those with no symptoms. It is worth noting that early in the pandemic there were no suitable antigen LFTs with sufficient sensitivity or specificity to be useful and scientific advisors did not believe asymptomatic infected individuals posed an infection risk. This position changed upon completion of a pilot of the direct LAMP technology which demonstrated that lower sensitivity tests could detect COVID-19 in asymptomatic individuals with high viral loads.

Ministerial responsibilities and decision making

4.174. Ministerial accountability for testing rested with the Health Secretary. Given its importance to the Government's overall strategy, the Prime Minister and No.10 took a close interest in progress and from time to time carried out stocktakes or 'deep dives' with relevant ministers, officials and advisers. No.10 officials and advisers sought updates on progress in order to provide assurance to the Prime Minister and to seek to help to remove blockers. No.10 also sought to ensure that funds were made available for key parts of the programme and that approvals were given as quickly as possible.

4.175. Throughout the pandemic, central government organisations continued to require the Cabinet Office's approval to commence procurements and award commercial contracts over a specified contract value. Treasury spending approval was also required for higher value contracts and/or where the proposed expenditure was considered to be novel, contentious or repercussive. Lord Agnew would take decisions on spend control submissions based on written advice from the GCF. From July 2020, fortnightly Commercial Spend Control Panels were introduced for higher value and more complex cases to enable the Minister to discuss proposals with commercial experts and other senior officials before making a decision. These were attended by the Minister of State, the Chief Operating Officer for the Civil Service and the Government Chief Commercial Officer (GCCO), plus senior representatives from HM Treasury (HMT) and other relevant government functions.

[224] Or saliva or the anterior nares.

Role of the CTT and other commercial professionals

4.176. The response to the pandemic required a huge increase in the variety of products, services, solutions and infrastructure that were needed and the number of contracts that needed to be let. The pre-existing DHSC commercial team was of insufficient size to deliver this uplift in commercial activity.

4.177. In mid-March 2020, the DHSC requested help from the GCF for commercial specialists to support the NHS and other agencies in their response to the pandemic. As part of the response, from 18 March 2020 commercial staff from the Cabinet Office, primarily from the Complex Transactions Team (CTT) were assigned to support DHSC on procuring the required goods and services to support an increase in testing activity. CTT at the time was under the leadership of Janette Gibbs as Acting Director who reported into the GCCO. CTT members joined government colleagues from the DHSC, PHE and other government departments. Also joining the team from 19 March 2020 were consultants from Deloitte[225] who were brought in by DHSC to assist with delivery and strategy development. Together, these people formed a blended commercial testing team performing necessary commercial, operational and project management activities, responding to the policy and strategy direction given from time to time by DHSC and/or No.10. The commercial testing team consisted of 25-30 individuals. The majority of this team were GCF commercial specialists from the Cabinet Office Complex Transactions Team; commercial specialists who operate as internal consultants and are deployed across HMG working on the most complex commercial challenges. The remainder of the team was made up of GCF commercial specialists from other government departments including MoD, DIT, DHSC and PHE, supported by a small number of consultants. The leadership team was made up of Beverley Jandziol (CTT), Tim Byford (CTT), Pam Doyle (CTT) and Lucy Mason (DHSC).

4.178. The engagement of the CTT into this commercial testing team followed the standard CTT 'internal consultancy model' (as described in paragraph 2.11.6 of Section B). This meant that the CTT worked for and under the direction of DHSC leads, and ultimately the DHSC SRO, to procure PCR and LFT testing equipment, supplies, infrastructure and services. The items procured were for use by organisations such as the NHS, PHE and by the network of Lighthouse Laboratories (and later Megalabs) which had been established.

[225] The Deloitte team included a number of leading partners such as Philip Coleman

4.179. Unlike normal CTT consultancy work, resources were not charged for during the initial phase of the pandemic. CTT resources were provided at no cost until the end of June 2020, and thereafter were charged for in line with usual processes.

4.180. The broad commercial activities that CTT were involved in as part of the blended team (and working with relevant technical, operational and departmental experts where required) were as follows: leading commercial workstreams; managing new offers across the various testing methodologies; supply market research and intelligence; scoping and piloting of new solutions; providing commercial input to inform policy development; early supplier engagement; supplier negotiations; contracting; drafting documentation (approvals, business cases, ministerial submissions, approval documentation, contract overviews and Contract Award Notices); contract termination; attendance at Boards and meetings; and engagement with Ministers and No.10.

4.181. These activities were conducted across the entire range of goods and services procured to enable delivery of the testing strategy. This includes the consumables needed to perform the tests and also for example laboratory services and logistics services. CTT also shared knowledge of the 2015 Regulations and government processes (approvals etc) with new commercial and other colleagues drafted in from outside the public sector. CTT in many cases led on risk assessment for new contracts, working closely with legal, finance and technical/scientific colleagues.

4.182. Despite being embedded in the DHSC for this work, Complex Transactions specialists remained Cabinet Office officials, and maintained their reporting communication lines through the Cabinet Office and ultimately to the GCCO (as described in Section A). I as GCCO received frequent written updates of commercial activity in this area.[226] Less formal contact was by way of emails and calls. This was helpful in order to escalate concerns where commercial best practice was not being followed.

4.183. Although health is a devolved matter, the activity of the commercial testing team helped to set up a testing infrastructure to cover the whole of the UK with facilities and services in all the nations. Officials in the commercial testing team met with counterparts from Wales, Scotland and Northern Ireland to discuss the impact of policy decisions and share insights on supplies and buying decisions.

[226] GRW/28 - [INQ000496711] and GRW/225 - [INQ000497242] as examples

Approvals

4.184. As described in Section B the Cabinet Office is responsible for the operation of the "Cabinet Office controls", a system of approving Government spend over a threshold value. This system is run by the Strategy, Assurance and Standards team (SAS) (formerly Commercial Continuous Improvement) which reports to the GCCO. Spending departments submit requests to this team which are then reviewed before setting before a Minister (at the time Lord Agnew, Minister of State at the Cabinet Office and Her Majesty's Treasury) for sign off. These controls applied to Test and Trace expenditure (including expenditure that occurred prior to the inception of Test & Trace), and the interaction between the DHSC and this system of controls is expanded in the sections below.

Phases of organisational development

4.185. Commercial experts from the Cabinet Office were embedded in the DHSC's testing commercial team between March 2020 to the end of 2020. CTT continued to assist DHSC for handover and project support from late 2020 to March 2021 (as well as acting as witnesses for judicial reviews and providing information for the NAO investigation into HMG contracts with Randox). Over that year, governance, processes, structures, and commercial priorities shifted, often rapidly and dramatically, as knowledge grew about the nature of the virus, new variants appeared, successive waves of infection took place and new technologies became available.

4.186. The work moved from emergency procurement, responding to and catching up on the immediate challenges of the early days of the pandemic, through to an increasingly business-as-usual approach to the commercial operations of what became NHS Test and Trace. We explain the organisational context and the buying activity in three phases:

4.186.1. Initial deployment – March 2020 to May 2020;

4.186.2. The establishment of NHS Test and Trace – May 2020 to August 2020;

4.186.3. The maturing commercial organisation in NHS Test and Trace – August 2020 to the end of direct Cabinet Office commercial support in March 2021.

March and April 2020 - initial expansion of PCR capability and antibody tests

4.187. As stated in paragraph 4.158, there was substantial Ministerial and No.10 interest in the testing programme. On 17 March 2020, a note recording the outcomes of the roundtable meeting mentioned in paragraph 4.158 was circulated.[227] A four-pronged approach to increase testing capacity was proposed and the Cabinet Office commercial team was assigned to assist in commercial activities for increasing NHS lab-based testing capacity.[228] A meeting on 18 March 2020 took place in DHSC to discuss what was required to set up COVID-19 Testing capability. The meeting was attended by DHSC Minister Lord Bethell, Professor Sir John Bell, Regius Professor of Medicine at Oxford University and specialist in Immunology & Genetics, and several civil servants from the Office for Life Sciences (OLS). A CTT Commercial Specialist, Dr Beverley Jandziol, also attended the meeting. It was quickly established that the UK needed to radically increase COVID-19 testing capacity and capability. It was noted that the entire capacity across the NHS was around 6,000 tests per day. Work was needed urgently to scale up daily testing capacity to meet the Ministerial target of 100,000 per day.[229]

4.188. Dr Jandziol joined a No.10 conference call with Office for Life Sciences (OLS) colleagues later that day which discussed the work needed to scale up testing capacity and the consequent procurement activity.[230] This became a daily meeting, which was initially set for the evening, and then moved to 7am daily. That call was routinely attended by Beverley Jandziol (CTT), Kathy Hall (DHSC Policy), Samantha Roberts (NHS Supply Chain) and SRO for setting up third party testing labs, Kirsten McLeod (OLS), Number 10 Special Advisers (including special adviser for health policy, Will Warr), Professor Sir John Bell, and various Industry representatives from pharmaceuticals and logistics.

4.189. 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.[231] 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 on three workstreams. The work undertaken by these workstreams expanded over time as the scope of the testing programme grew. The three initial workstreams were:

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[227] GRW/221 - [INQ000478783]
[228] GRW/226 - [INQ000055915]
[229] GRW/227 - [INQ000473907]
[230] GRW/228 - [INQ000477236]
[231] GRW/229 - [INQ000471006]

4.189.1. NHS Covid 19 lab-based testing – Dr Jandziol (supported by other commercial colleagues)

4.189.2. Third Party Covid 19 lab-based testing – Tim Byford

4.189.3. Rapid Covid 19 antibody testing of key workers – Pam Doyle (and later surge capacity and expansion of commercial labs).

4.190. On 2 April 2020, the DHSC's publication of the National Testing Strategy expanded on these workstreams and restated the work to be carried out in five pillars:[232]

4.190.1. Pillar 1: Scaling up NHS swab testing for those with a medical need and, where possible, the most critical key workers;

4.190.2. Pillar 2: Mass-swab testing for critical key workers in the NHS, social care and other sectors;

4.190.3. Pillar 3: Mass-antibody testing to help determine if people have immunity to COVID-19;

4.190.4. Pillar 4: Surveillance testing to learn more about the disease and help develop new tests and treatments;

4.190.5. Spearheading a Diagnostics National Effort to build a mass-testing capacity at a completely new scale.

Key procurements in March - April 2020

4.191. In support of these 'Pillars' the commercial testing team worked to increase the number of RT-PCR tests available each day which included awarding contracts to expand the infrastructure and logistics required to deliver RT-PCR testing capacity and capability. For example, on 7 May 2020 the team reported to the GCCO that it had secured deals with Nanopore, Novacyte and Hologic to increase potential testing capacity by 76,000 tests a day from May / June 2020 onwards.[233] In awarding these contracts the team contacted suppliers on existing NHS and PHE frameworks and frequently ran into capacity problems - the needed supplies were not available in sufficient quantities. Astra-Zeneca and GSK helped by giving access to their supply chains and further capacity was obtained from these suppliers. A call to industry was made on 8 April 2020 which opened up some other supply routes.[234]

[232] GRW/230 - [INQ000106325]
[233] GRW/231 - [INQ000496908]
[234] GRW/232 - [INQ000477280]

4.192. It was also within the remit of the commercial testing team to purchase antibody LFTs and to explore additional testing technologies that might prove suitable for different test use cases e.g. mass testing, near-patient testing and to commission pilots and fund development activity. These efforts are described in more detail below.

RT-PCR expansion

4.193. At the beginning of the pandemic, RT-PCR was the only widely recognised testing methodology available. The nature of RT-PCR testing restricted procurement options and strategies:

4.193.1. Global demand for supplies and equipment substantially outstripped supply and manufacturing capacity. This was the case for all commercial activity for testing;

4.193.2. Supply production was further impacted by the effects of the pandemic itself, for instance, lockdown and the closure of production facilities in China, and the availability and accessibility of raw materials. Again, this was the case for all commercial activity for testing;

4.193.3. The requirements for the supply chain were complex, particularly with regard to RT-PCR testing. The following factors affected decision-making:

- The timeframe for sample degradation limited logistics options;
- Some reagents needed in RT-PCR testing required cold-chain transport and storage;
- There was competing demand for reagents, for example ethanol is used in RT-PCR testing but it is also used in sanitising products, where demand also increased dramatically;
- Testing protocols varied, for example, some had a bill of materials of 60 items. Not only was there huge complexity in the number of consumables that were required, often they could not be substituted due to technical compatibility with equipment or substitutes simply were not available.

- Availability of qualified personnel, for example technicians to resource laboratories analysing tests;
- Technical compatibility. The trend across the NHS had been to opt for PCR equipment that was brand-specific, in that only specific reagents and consumables were compatible for use with those specific PCR machines. As a result, the NHS had become increasingly reliant on large global suppliers, which significantly limited supply options. Even if a substitute was technically compatible, manufacturers would not endorse use and warranties would be compromised/invalidated.

4.194. RT-PCR testing requires people, premises (laboratories at BSL-3 standard), equipment, consumables, services (such as clinical waste disposal), logistics and infrastructure, transport, and effective processes supported by IT. It is difficult to decouple these elements from each other because all are needed for an effective "test" to be delivered. The availability of these different elements were a limiter and challenge to the scaling up of testing. The procurement of laboratory capacity and capability (including fitting out) was an essential part of ramping up the UK's testing capacity.

4.195. As well as working intensively on behalf of the DHSC to procure RT-PCR consumables and equipment (for example to increase the capacity in existing NHS laboratories), the commercial testing team was involved in identifying and equipping 'lighthouse' laboratories; third-party commercially operated labs that received samples and generated results (see paragraph 4.150 for details on the function of the commercial testing team). In some cases, DHSC had progressed early discussions with laboratory suppliers ahead of additional Cabinet Office commercial capacity being deployed. Early CTT support required focus to introduce commercial rigour and best practice into contracting for laboratory services. For example, Cabinet Office support included:

4.195.1. Contracting on behalf of DHSC for the first 'lighthouse lab' which was the UK Biocentre in Milton Keynes. This was an operational lab that was about to cease operating. A decision was taken to step in and commission it to deliver COVID-19 testing.[235]

[235] GRW/233 - [INQ000477917].

4.195.2. In mid-March 2020 DHSC had entered into dialogue with Randox, a Belfast based laboratory, alongside similar commercial testing providers. Whilst Randox had the capability to perform RT-PCR testing, it had limited capacity. DHSC signed a contract on 30 March 2020, and by the end of March, Cabinet Office colleagues were working with Randox to ramp up its capacity to deliver an end-to-end testing solution for care homes. This support included for example working with operational and contract management colleagues to improve demand forecasting for Randox tests to enable them to more effectively manage their staffing.

4.195.3. Other laboratories that were fitted out to increase UK laboratory capacity included AstraZeneca and GSK. Within weeks, the lighthouse laboratory footprint was expanded to include the Medicines Discovery Catapult in Manchester, AstraZeneca in Cambridge and the University of Glasgow.

4.196. Whilst a focus of the team was on securing capacity for conducting tests (by buying consumables such as swabs and reagents for use in existing laboratories as well as contracting for commercial end-to-end laboratory services), the expansion of national testing required the establishment of a large-scale, complex logistics organisation to support delivery of tests. For example, it was necessary to award contracts including site leases for drive up/walk up testing sites, service contracts for packing of swab test kits, service contracts for operation and resourcing of test sites (including conducting swabbing), transportation of samples to and from test sites and laboratories, delivery contracts for home testing kits, and many other related logistics and support services.

4.197. Establishing services for some of the above activities included complex negotiations with a large range of strategically important suppliers, and ultimately ongoing liaison and close cooperation with these suppliers to support ongoing delivery of the testing infrastructure as well as seeking their support in scaling up services to meet increasing capacity targets. The skilled commercial staff that the Cabinet Office supplied from March 2020 were well qualified to deal with these negotiations because of their accredited commercial expertise and their close collaboration with DHSC and other scientific and clinical colleagues. Ongoing liaison with suppliers was needed to help overcome short-term issues, caused for example by shortness of supply of key components in a competitive and disrupted market. The Cabinet

Office role in this operation was confined to the supply of these staff, who worked to the direction of DHSC officials and under the authority of the DHSC Accounting Officer.

4.198. The 'Trace' operation also in time required support for the setting up, for example, of call centres and IT provision. Though by no means an exhaustive list, by way of example, Cabinet Office officials negotiated contracts for the above services with organisations such as:

4.198.1. Sodexo, Serco, G4S (for example for management and operation of testing sites)

4.198.2. Amazon, DHL, Post Office, Kuehne + Nagel (for a range of logistics services)

4.198.3. Boots and Reed (for example for resource services related to PCR testing at test sites and laboratories)

4.199. This end to end operational infrastructure required careful balancing to ensure capacity remained consistent across the system. Unless there were enough swabs and tubes at testing sites, and staff to manage them, and logistical capacity to transport the samples to laboratories, the additional laboratory capacity that had been secured by the commercial testing team could not be fully utilised. The commercial testing team led the negotiation and execution of contracts across the entire operational landscape, including all steps in the testing supply chain and all testing technologies. These complexities did, however, lead to commercial challenges. As an example, no-one knew how long the emergency period would last, so early contracts were let for short periods in line with guidance, which led to further work when these contracts needed to be relet or extended.

4.200. There were times for example when there was under-utilisation of laboratory capacity or test centre capacity due to bottlenecks elsewhere in the system. A visit I as GCCO made to the Milton Keynes lab (22 September 2020) revealed that the lab was in fact idle from Sunday afternoon to Tuesday morning due to lack of samples, resulting in a rebalancing effort to ensure consistent delivery of samples and hence overall much higher network capacity. I shared my recommendations with Baroness Harding, Philip Coleman (Deloitte partner) and Professor Dame Anna Dominiczak (Director of Laboratories, DHSC) who went on to rank the recommendations by the percentage of additional testing capacity they would create in order to prioritise the

recommended improvements. For example, deactivating the virus before a sample was shipped to a lab could increase testing capacity by 25%.[236]

4.201. As testing scaled up, the commercial team assessed existing supply contracts to ensure capacity remained as consistent as possible across the system and supported negotiation of new contracts (for example with Hologic, Abbott, Primer Design, Novacyte and Thermofisher) where required.[237]

4.202. Consumables like swabs and reagents for RT-PCR testing were purchased for NHS operated labs and, on occasion, third party labs (where there was a specific bottleneck in supply, such as Ethanol[238]). Historically NHS-operated labs sourced their own supplies directly, however, due to increased global demand during the pandemic there was, for many products, benefit to centralising this procurement activity. Centralisation prevented labs from obtaining different rates from suppliers, enabled central prioritisation of deployment, and was the preference of multinational suppliers who were under substantial pressure from buyers internationally. In the case of third party and commercial labs, typically consumables were purchased by the laboratory itself via existing supply routes, however where a substantial ramp up in capacity was required, or a specific bottleneck occurred, DHSC central purchasing arrangements were at times used to bolster their supply.

4.203. The Cabinet Office commercial specialists identified existing framework agreements that could be used for procurement of testing supplies, including the PHE Microbiology framework. However, although some contracts for supplies and equipment used this framework, its upper limit would have been surpassed by the aggregate value of contracts that were being let for testing, given the very high value of the procurements required to meet the UK's emerging testing needs. Cabinet Office officials later encouraged the re-procurement of a new expanded PHE microbiology framework, delivered by PHE commercial colleagues.

4.204. Where it was not possible to utilise the PHE framework directly, the team sought to mirror the framework terms when contracting directly with a supplier that was on the framework, in order to speed up contracting and ensure the terms and conditions were tailored to the supply. Due to the fast paced nature of the market and innovation of new products, not all suppliers were available via existing frameworks. New suppliers are not permitted to be added during the lifetime of a framework,

[236] GRW/234 - [INQ000477290], GRW/235 - [INQ000478822]
[237] These contracts are available from UKHSA.
[238] Demand for Ethanol had soared because of its use in hand sanitiser.

although this is possible in respect of dynamic purchasing systems (where available, which in this case they were not at the time). Where a contract with a non-framework supplier was required, the preference was to utilise the relevant standard DHSC terms and conditions as these were the most straightforward for both parties to negotiate on. Guidance issued by the DHSC Commercial directorate on 6 April 2020 by Rick Webb, Head of Procurement Policy, Systems and Intelligence recommended that commercial teams buying PPE or tests use a DHSC standard contract for Goods amended specifically for COVID-19.[239] The standard process for contracting with a supplier new to DHSC also included completing a 'new supplier form' which included a declaration regarding conflicts of interest.[240]

4.205. Some examples of DHSC utilising available frameworks and framework terms are:

4.205.1. Certain supplies from Thermofisher (consumables and equipment), to the best of my belief were purchased via the framework.

4.205.2. Certain reagents from Hologic for use in NHS laboratories were procured via a direct award, however the team used the terms of the PHE Microbiology Framework as a basis for the contract.[241]

LFT Antibody testing – first generation

4.206. The use of Antibody LFTs was identified early in the pandemic as a potential route to increase testing capacity, and in particular, to deliver daily testing to key workers to enable their return to work. Antibody tests confirm whether the person giving the sample has had the disease. At the time, it was believed that having had the virus may confer immunity from future infection , but on 24 April 2020 the WHO discussed (and rejected) the possibility of an "Immunity passport" which would allow e.g healthcare workers to return to work after infection.[242] A major UK study, SIREN, was launched by the NIHR to investigate this point.[243] On 14 January 2021 PHE published preliminary results from SIREN suggesting that previous infection provided some immunity for at least five months, but people may still carry and INQ000512996transmit the virus.[244]

[239] GRW/236 - [INQ000496903]
[240] GRW/237 - [INQ000496716]
[241] GRW/238 - [INQ000471011], GRW/239 - [INQ000512996]
[242] GRW/240 - [INQ000496763]
[243] GRW/241 - [INQ000496762]
[244] GRW/242- [INQ000535032]

4.207. Nonetheless, without that knowledge at the time, DHSC directed the testing commercial team to buy LFT antibody tests. At a meeting of the COVID-19 Strategy Ministerial Group on 1 April 2020 it was confirmed that purchase of tests under Pillar 3 was well underway with 17.5 million tests purchased.[245]

4.208. The global demand for antibody tests was very high, with many other countries purchasing large volumes of LFT antibody tests from March 2020. Concerns were expressed at the most senior levels of the DHSC that the UK should procure LFT antibody tests to avoid being left with nothing.[246] At that time, no samples had been acquired or validated, so it was decided that the procurement and validation would occur simultaneously. Validation was a challenge as the serum required was also in short supply, and many suppliers refused or were unable to send samples because the demand was so high.

4.209. Unfortunately, none of the first-generation tests passed validation. This testing was carried out by PHE and checked the sensitivity and specificity of the antibody tests, together with any kit failures against a pre-determined level of acceptability. Cabinet Office officials communicated this to the suppliers, and returned most of the tests, recouping refunds negotiated by the testing commercial team. It was challenging to recover funds as there were limited contractual levers available due to the speed at which contracts had been placed and the approach of parallel procurement and validation. Those LFT antibody tests that were not returned were used for research purposes (for example in prevalence tests such as the REACT study[247]).

LFT antibody tests – manufacture in the UK

4.210. In parallel with this purchasing activity, work commenced on developing the UK's capability to manufacture bespoke LFT antibody tests to address the perceived need. In April 2020, the National Institute of Health Research (of which DHSC is the ultimate parent organisation) supported the establishment of a consortium of suppliers, led by Abingdon Health, to develop and ultimately manufacture a bespoke UK antibody LFT. NIHR provided research & development grant funding to support this activity. From June 2020, Cabinet Office commercial specialists began to assist to a greater degree and led negotiations on behalf of DHSC with Abingdon Health from June 2020 onwards. Multiple contracts were awarded covering: advanced buying of specific components for use in the test that were in short supply;

[245] GRW/243 - [INQ000088605]
[246] GRW/244 - [INQ000477908]
[247] GRW/245 - [INQ000496757]

manufacturing and supply of a UK based antibody LFT (with a range of volume options included within the contract and a cancellation option if the tests did not meet HMG requirements); and a profit sharing agreement to cover a scenario where the UK developed tests were sold to overseas customers. Ultimately, as a result of the asymptomatic testing pilots and the entrance of antigen LFTs into the market, HMG strategy moved away from the use of antibody LFTs. From September 2020 onwards, Cabinet Office supported DHSC in negotiating the termination of the Abingdon Health contract. Circa 1 million units had been procured and these were utilised within ongoing surveillance testing studies (such as the REACT study see para 4.209).

May-August 2020

4.211. On 7 May 2020, DHSC announced that Baroness Harding had been appointed by the Prime Minister to lead the UK's testing programme, reporting to the Prime Minister and the Cabinet Secretary.[248] Ministerial accountability for testing remained with the Secretary of State for Health and Social Care.

4.212. On 28 May 2020, NHS Test and Trace was established as an arms-length body of DHSC, and Baroness Harding was appointed as its Chief Executive. The mission of Test and Trace was to "help break chains of COVID-19 transmission and enable people to return to a more normal way of life".[249] This was to be achieved by fast, widely available testing which would in turn be used to drive contact tracing.

4.213. Cabinet Office commercial specialists working in the commercial testing team at the time were moved to the new organisation. The SROs for Test and Trace and the Accounting Officer were all DHSC officials, and governance was exercised through working groups reporting to Lord Bethell, a DHSC Minister.

4.214. The organisational structure changed at this point, with Test and Trace operating in several directorates including Testing, Contact Tracing, and the Joint Biosecurity Centre (JBC).[250] Cabinet Office commercial staff including members of the CTT supported work in the Testing directorate. The CTT retained their reporting communication lines through GCF and ultimately to the GCCO. As shown in an organogram from 8 May 2020, Dr Jandziol and other Complex Transactions colleagues continued to work for and on behalf of the DHSC in critical commercial

[248] GRW/246 - [INQ000477247], GRW/246 - [INQ000087170]
[249] GRW/248 - [INQ000477263]
[250] GRW/249 - [INQ000477256]

roles.[251] The nature of the commercial work undertaken by the team did not change radically as a result of the restructure, and the core team continued to draft business cases, pilot new technologies, draft ministerial submissions, obtain approvals and negotiate contracts.

4.215. A number of external leaders were brought into the Test and Trace organisation on 3 month secondments or short term contracts. I believe these included Emma Stanton (Director for Supplies and Innovation), Alex Cooper (Mass testing Development Director, from the Army), Sarah Jane Marsh (Test Divisional Director before Mike Coupe), Tony Prestedge (Chief Operating Officer, from Nationwide) and Mike Coupe (Testing Divisional Director, from Sainsbury's), but authoritative data would be held by UKHSA. This constantly changing and evolving leadership in the initial months of the testing programme caused some challenges and disruption for the commercial team, as new leadership members had to be brought up to speed on the work of the team, and educated on commercial best practice in the public sector, appropriate governance for spend of this magnitude and commercial due diligence. Sometimes there was a lack of understanding of the rigour required in procuring in a public sector setting. This put commercial colleagues, including those from Cabinet Office, under additional pressure and they had to at times challenge recommendations. New colleagues not familiar with public sector purchasing at times overestimated the flexibility granted by the use of Regulation 32, and the need for justification and documentation of all procurement decisions taken.

4.216. Whilst day-to-day the Cabinet Office team were reporting into and supporting DHSC and Test & Trace with delivery of its testing strategy, where a specific commercial issue or risk was identified the Cabinet Office team felt confident in challenging the approach and recommending alternatives knowing that they had an escalation route to the GCCO. As an example, Test and Trace presented a plan to Ministers at COVID(O) on 6 August 2020 that outlined how it would build Winter testing capacity to 800,000 tests/day.[252] The commercial testing team had expressed some reservations regarding this plan, especially on the extent of commercial engagement in expanding testing facilities, and the assumption that all new capacity would be PCR. I requested and received a briefing note for the COVID-O meeting.[253] As GCCO, I supported the position taken by the commercial testing team.

[251] GRW/250 - [INQ0004788091]
[252] GRW/251 **[INQ000089946]**
[253] GRW/252 [GWI_INQ000496731]

4.217. Following the formation of NHS Test and Trace, new daily testing capacity targets were set by the Secretary of State for Health and Social Care. These said that the organisation should have 200,000 daily testing capacity by the end of May 2020 and 500,000 a day by the end of October 2020.[254] As stated in the paragraph above, NHS Test and Trace had the ambition to increase this to 800,000 tests/day before the 20/21 winter peak.

Move to mass testing

4.218. In this period, it was apparent that there was a need to leverage technological advances which were emerging and, in due course, prepare for a second wave of infections expected in the winter.

4.219. During this phase of the pandemic, key commercial team activity included:

4.219.1. Continued centralised procurement of consumables where a need was identified.

4.219.2. Publication of the Prior Information Notice (PIN) and commencement of market engagement as part of a tender process for a new PHE Microbiology framework. Cabinet Office officials supported PHE with commencing this process, identifying that there would be a long term need for a compliant route to market for buying testing consumables.

4.219.3. Further expansion of the RT-PCR laboratory network. This included scaling up existing laboratories, onboarding new laboratories, expanding logistics and increasing the number of testing sites.

4.219.4. Commercial support to help existing laboratories to adapt their processes and thus scale up their throughput. During this period, early work to develop proposals for contracting for 'Megalabs'[255] also commenced.

4.219.5. Early work on ePCR technology. This was an alternative form of PCR testing. ePCR has a different protocol within the laboratory but was expected to be lower cost and higher throughput. Initially the technology was tested within the existing Lighthouse Labs network, with the ambition to expand the technology to new 'Megalabs' once

[254] GRW/253 - [INQ000088649], GRW/254 - [INQ000090086]
[255] Larger new-build testing laboratories with high automation.

proven as a concept. Work for the commercial team included business case support and negotiation with suppliers of this technology.

4.219.6. More serious exploration of other testing and point of care technologies including LAMP and LamPORE through funded pilots.

4.220. Where required and as a result of the value of a proposed contract, business cases continued to be scrutinised through the relevant CO Controls and HMT spending approval purchases. The Cabinet Office team deployed to work within DHSC had an excellent working relationship with the CO Controls team (led by William May, acting Director) and would work collaboratively to accelerate approvals as much as possible. The Controls approval processes are described from paragraph 2.26 onwards, and the relevant guidance was summarised in a Commercial Policy Guidance Note issued on 9 April 2020. The CO team in DHSC were also able to highlight risks to the CO Controls team so that these could be considered during approvals and appropriate conditions applied to approvals where required.

4.221. As GCCO, I remained sighted on key procurements and at times raised concerns about the continuing use of regulation 32. For example, I questioned an expansion of Lighthouse Labs in July 2020 and sought to limit reliance on regulation 32 which the DHSC had proposed for spend supporting these expansions, for instance by using direct awards to procure further automation, new equipment and process improvement to existing Lighthouse Labs and to develop new sites including by supplying some of them with equipment reagents and consumables.[256] This matter was escalated to the Cabinet Secretary and resolved in a meeting chaired by Simon Ridley as Director General of the COVID-19 Taskforce (see paragraph 1.8) on 24 July 2020, which noted where improvements were needed in process and resourcing levels in Test and Trace.[257] The contracts were subsequently approved following changes in approach requested by the Cabinet Office and HMT.[258]

Asymptomatic testing pilots: LAMP and LamPORE

4.222. Throughout 2020, new technologies emerged that had the potential to (and in many cases ultimately did) contribute to the UK's testing capacity. Alongside their colleagues from DHSC and other departments, the CTT specialists worked to identify and develop these opportunities, and then to negotiate contracts for supply which were ultimately entered into by the DHSC. Key initiatives included

[256] GRW/255 - [INQ000497266], GRW/257 - [INQ000471020], GRW/256 - [INQ000471019]
[257] GRW/258 - [INQ000477938]
[258] GRW/259 - [INQ000497266], GRW/260 - [INQ000496739]

point-of-care and near point of care technologies including RT-LAMP and LamPORE.[259]

4.223. LAMP was identified within the DHSC testing programme as a potential route to mass testing. In May 2020 Dr Jandziol met with the management of a hospital in Hampshire which was using rapid LAMP testing to triage patients arriving at A&E. Dr Jandziol contacted the scientists and the supplier of the portable testing solution and carried out further research on LAMP, drafting a scoping paper.[260] At the same time a proposal for large-scale pilot of LAMP technology was submitted directly to No.10 by Professor Keith Godfrey of University Hospital Southampton.[261] Dr Jandziol worked with Professor Godfrey to modify the pilot to reduce the cost, size and scale while also working in parallel with the Hampshire scientists on a separate pilot for mobile LAMP testing for care homes using a mobile 'lab in a van'.

4.224. Professor Godfrey was funded by Test and Trace[262] to build a trial of LAMP testing units to prove whether the technology was scalable. The approach they took led to a multi stage process with many internal steps. The experience of scale up processes of this kind, reinforced by the Ventilator Challenge, led me to believe this effort would prove very challenging, as indeed it did. As a result a project was instituted to design and build a 'LAMP in a box' automated system. This was run by the team from McLaren F1 (contracting as PurpleSector and subcontracted to PA Consulting) who had helped the Penlon Ventilator team. The advantages of a self-contained and automated testing module included the ability to build more to meet changing demand, increased consistency of results which in turn would allow for units to be distributed around the country. This in turn would reduce the time taken for a test to be processed, as the 12-18 hours of transit time to get a sample to a centralised testing centre dramatically reduced. Additionally it avoids the risk inherent in a large workforce in a central lab who might themselves catch COVID-19. Being automated, the system also required 87% less labour. By the end of the pandemic two units had been trialled and tested, and the units were also enabled to run PCR tests. The plan was to ramp up capacity to 100,000 tests per day from the Southampton base and the second unit aimed to automate the process in order to make it faster and more efficient. Given it could be tested with saliva rather than swabs, LAMP presented benefits to support hospital-based staff testing and could be an alternative for

[259] GRW/261 - [INQ000512991]
[260] GRW/262 - [INQ000497243]
[261] GRW/263 - [INQ000477939]
[262] GRW/264 - [INQ000513015]

vulnerable groups such as children with special needs who found swabbing stressful. However, while faster than PCR, LAMP was still a lab-based testing protocol which did not fulfil the use case for extensive mass testing. For this reason, LFTs were ultimately preferred. LAMP, among other technologies investigated during the pandemic, could prove a useful alternative technology to PCR testing for potential future pandemics as it can apparently be adapted for use with any disease.

4.225. In parallel, a group known as the Manufacturing Industry Coalition, which comprised representatives from industry and government, worked on speeding up and taking costs out of the assembly (by standardisation and automation) of the test kits used by citizens to submit a sample for PCR testing. Because of the speed at which this kit production was stood up, a wide variety of e.g. test tubes were procured. This variation in test tubes had a very negative effect on the capacity of the testing labs; the robotic systems could not handle different formats of test tubes or lids. By steadily standardising kits, testing capacity would also be increased.

4.226. The initial results from the LAMP pilots in June 2020 appeared to be promising. The results implied that COVID-19 could be detected in asymptomatic people using a rapid lower sensitivity diagnostic test, offering a credible alternative testing technology for the programme.

4.227. On 20 July 2020 No.10 started to draft proposals for mass testing of asymptomatic people. This was based on a pilot proposal for city-wide testing using direct LAMP technology, originally referred to as the Phoenix Programme.[263]

4.228. The success of the early LAMP pilot led to a further proposal from Professor Godfrey in July 2020.[264] Professor Godfrey's proposal was considered in a meeting about asymptomatic testing with the Prime Minister, the Secretary of State for Health and Social Care, Baroness Harding and others, held on 24 July 2020[265] This work resulted in the piloting of whole population screening in July and August 2020 with the use of RT-PCT and RT-LAMP technologies as set out in Professor Godfrey's proposal. This was the origin of "Project Moonshot", later "Operation Moonshot" which is discussed in more detail below.

August 2020 - March 2021

Appointment of Jacqui Rock and organisational change

[263] GRW/265 - [INQ000471017], GRW/266 [INQ000471018]
[264] GRW/267 - [INQ000471022]
[265] GRW/268 - [INQ000218334], GRW/269 - [INQ000316388]

4.229. In August 2020, Jacqui Rock was appointed as Chief Commercial Officer of Test and Trace to establish a more permanent Commercial Directorate within Test and Trace. She had previously been Commercial Director of the Defence Infrastructure Organisation within the Ministry of Defence, and was employed by the Government Commercial Organisation (as all senior commercial professionals within HMG are, as outlined in Section B). Once she was appointed, the commercial experts from the Cabinet Office including members of the CTT reported to her for the commercial delivery of testing capability, while retaining a dotted line relationship with me as GCCO. While Ms Rock expanded her new organisational structure, Cabinet Office commercial staff continued to deliver critical roles to Test & Trace to maintain existing testing capacity as well delivering the DHSC policy to scale up testing further.

4.230. Shortly before Ms Rock was appointed, Emma Stanton, Director for Supplies and Innovation took over the responsibilities in the Testing programme previously performed by Samantha Roberts (Director of Covid Testing Supplies)[266]. She was recruited externally.

4.231. Ms Rock introduced a new commercial organisational structure which was aligned with the Test and Trace business sectors, and was less project-based, as would be expected of a maturing organisation.[267]

4.232. From around September 2020, many OGD (Other Government Department) civil servants left Test and Trace and returned to their home departments, including some of the Cabinet Office commercial specialists. This rotation was necessary as many staff had been working under sustained pressure for months, some of them had ongoing jobs that they needed to return to in their home departments and it was desirable to build a larger, more permanent commercial team in Test and Trace to manage a growing portfolio of contracts. Jacqui Rock used the Commercial Capability team, a Central Commercial Team (as outlined in Section A) to acquire external resources to alleviate the workload on the small commercial team that had been in place before she took over. She recruited civil servants into her team from other Government Departments. She also brought in consultants such as Efficio, 4C Associates and EY as well as independent contractors via the Public Sector Resourcing framework. McKinsey and PA Consulting were deployed within the

[266] Role descriptions for these two Directors are held by UKHSA
[267] GRW/270 - [INQ000383572], Slides 2 and 14 relevant

Supply Chain Team to help with horizon scanning and the triaging of solutions, thus taking on non-commercial work from the commercial team.[268]

4.233. Ms Rock grew the core commercial team from around 25 to over 100 people. This was a welcome increase in resources, but posed a challenge for the original team as team members needed to perform knowledge transfer and handover of work to help get new team members familiar with the business context, the current contract portfolio, and commercial processes in Test and Trace. Whilst Ms Rock onboarded permanent resources into her new organisational structure, Cabinet Office commercial staff including those from CTT continued to take leadership roles across some priority areas.

4.234. From August through to March 2021, Test and Trace's priorities were delivering the testing strategy including mass testing (later to become known as community testing), building additional capacity for winter and delivering a quarantine managed service. As with all NHS Test & Trace operations, all people in the commercial team ultimately acted under the direction of DHSC.

4.235. From September 2020, Dr Jandziol was the Operation's Commercial Lead, a strategic role across the programme. Chris Hall from the Cabinet Office took on the role of Commercial Lead specifically to support a project to manufacture lateral flow tests in the UK, as detailed further below. Both of these roles supported the delivery of community testing.

4.236. At the end of 2020, at the request of Ms Rock, Dr Jandziol stayed on in a consultancy / advisory role mainly to support the transfer of knowledge and to provide continuity of expertise to inform the handling of key issues related to the testing strategy during this period. At that time some applications had been made for judicial reviews of procurement decisions. The responses were supported by relevant Cabinet Office officials where they had been involved with the original contracting activity. Dr Jandziol provided continuity of corporate memory and insight into historical decision-making. Dr Jandziol's involvement with testing procurement concluded in Spring 2021.

4.237. Tim Byford, an SCS1 from the Cabinet Office CTT transitioned permanently across to a role within Test & Trace at the end of December 2020 to work under Jacqui Rock and lead on the establishment of a managed quarantine service.

[268] Further detail on the tasking of these consultants is held by UKHSA.

No.10's increasing focus on mass testing

4.238. As discussed in para 4.228 above, a meeting was held with the Prime Minister about asymptomatic mass testing and in particular on the LAMP approach on 24 July 2020.[269] At this meeting, it was noted that the Government needed to have procurement and supply chain arrangements in place to roll out tests and scale up quickly.[270]

4.239. At a meeting on 3 August 2020, it was confirmed that the Prime Minister was keen to take an ambitious approach to testing the whole of the country and discussions turned to how this might be achieved operationally.[271]

4.240. On 5 August 2020, the Prime Minister held a meeting about mass testing, in which he pressed to deliver population level testing by October 2020. That plan included an action for the DHSC to urgently discuss with HMT the cost of such population level testing. The Prime Minister stressed that he would like as much of the supply chain to be in the UK as possible.[272] He agreed to support that a week later in a meeting with Baroness Harding by issuing a call to arms to manufacturers. In the 5 August meeting, the Prime Minister was also clear that the Cabinet Office and HMT should provide all financial and commercial approvals to allow this work to proceed urgently, with exemptions provided from usual process.[273]

Changes in DHSC testing procurement approval limits and process

4.241. On 6 August 2020, Test & Trace proposed to the COVID-O meeting that all contract awards with a value over £100m should be approved by a Ministerial Investment Group to include CST, Lord Bethell and me; that this Group should receive recommendations from an investment board chaired by the DHSC Finance DG and attended by CO and HMT officials; and that contracts <£100m would be approved through a DHSC Senior Officials meeting.[274]

4.242. On 14 August, Raghuv Bhasin, Chief of Staff to Baroness Harding, confirmed via email to the Cabinet Office the new delegations and process with DHSC for commercial and financial approvals. It was also confirmed that a new weekly

[269] Agenda GRW/271 - [INQ000218333], documents produced GRW/272 - [INQ000062435], GRW/273 - [INQ000137242] readout GRW/274 - [INQ000233914]
[270] GRW/274 - [INQ000233914]
[271] GRW/276 - [INQ000471023]
[272] One result of this was the programme to manufacture antigen LFTs in the UK described in paragraph 4.248 onwards
[273] GRW/276 - [INQ000471024]
[274] GRW/277 - [INQ000477261]

Finance and Investment Board would be implemented, chaired by Donald Shepherd (CFO of Test & Trace).[275] The new approval regime was summarised thus:

4.242.1. Financial Delegation

>£100M - David Williams (DHSC 2nd PUS), Chief Secretary to the Treasury (HMT) and Lord Agnew (CO)

£25-100M - Andy Brittain (DHSC FD) and Melinda Johnson (DHSC Commercial Director)

<£25M - Donald Shepherd (NHS T&T CFO) and Jacqui Rock (NHS T&T CCO)

4.242.2. Contract signing Delegation

Grade	Contract signature
Chief Commercial Officer SCS2	Over £500 million
Commercial Senior Civil Servant 1	Up to £500 million
Commercial Civil Servant G6	Up to £10 million
Commercial Civil Servant G7	Up to £500,000
Commercial Civil Servant SEO	Up to £250,000
Commercial Civil Servant HEO	Up to £100,000

4.242.3. These delegations would be monitored as part of the audit of Departmental accounts.

4.243. At around this time, the Finance and Investment Board (mentioned in paragraph 4.231 above) was established and formally made spending decisions as appropriate to their authorities. Jacqui Rock and others from DHSC presented to the Finance and Investment Board regularly, including with detail regarding a forward pipeline of contracts that the Board would be asked to consider. The Director of the Cabinet Office Controls team also attended regularly to maintain visibility of activity within the organisation.

4.244. On 28 August 2020, the Cabinet Office and HMT wrote to the Secretary of State for Health and Social Care saying they had considered the proposal for commercial and financial approvals for the Test and Trace Programme.[276] The Cabinet Office

[275] GRW/278 - [INQ000477922], GRW/279 - [INQ000477959]
[276] GRW/22 - [INQ000473893]

and HMT agreed the proposal to raise the DHSC's approvals limits and expedite approvals process, subject to conditions. This was expressly granted as an exception, noting that the scrutiny and challenge of the Cabinet Office and HMT controls process should remain in place to prevent poor value for money and misuse of public funds. The letter noted that David Williams of DHSC remained Accounting Officer, and sought that Cabinet Office and HMT continued to be involved in early discussions on key policy choices, both to provide constructive challenge and to support financial oversight.

4.245. Cabinet Office and HMT agreed revised delegations:

Type of approval	'Approval owner'	Then current	Agreed
Spending	HMT	£100m within DHSC	£100m within DHSC
Commercial	CO	£10m within DHSC	£100m within DHSC
Digital	GDS	£0	Initially £10m within NHS T&T
Professional services	CO	£200k within NHS T&T	£1m within NHS T&T
Senior Salary	HMT	<£150K within DHSC	<£250k within NHS T&T and a cap of 25 people above £150k

4.246. This agreement was subject to several conditions including that:

4.246.1. All Test and Trace expenditure be tracked through a pipeline of contract awards shared with the Cabinet Office and HMT.

4.246.2. Any Test and Trace expenditures over £100m were to be subject to Ministerial approval by Lord Agnew and CST. Where appropriate this could be agreed at the Ministerial Committee on which Lord Agnew, CST, Catherine Little (attending as HMT representative) and I as GCCO (attending as Cabinet Office commercial representative) were

to sit. Approvals sought outside that Ministerial Committee process were to require a five day period for review and approval.

4.246.3. Any novel, contentious or repercussive expenditures would be considered at official level, but if judged by Cabinet Office and HMT official level to require Ministerial approval, they would be escalated to Lord Agnew and CST for sign off.

4.246.4. The approvals delegations and processes were to be reviewed in four months.

Change of strategy on testing technology

4.247. Antigen LFTs had become available in the summer of 2020. These tests look for signs of the virus itself rather than antibodies, which are produced by the test subject as a response to infection by the virus. Because a result is delivered in 30 minutes, antigen testing was deemed a good candidate solution for mass testing. Throughout August 2020, the commercial team supported Emma Stanton, the Director for Supplies & Innovation, in a series of supplier engagement sessions to collate information about potential suppliers of LFTs.

4.248. At about the same time, the first UK manufactured antibody LFTs had been produced and were undergoing validation. By this time the testing strategy was evolving and it came to be understood that past infection of the virus did not necessarily lead to immunity, particularly due to the emergence of an increasing number of variants.

4.249. The Chancellor of the Exchequer chaired a meeting on mass population testing on 19 August 2020. Baroness Harding provided an update on progress towards achieving population-level testing by early November. At this stage, multiple testing methodologies were being pursued in parallel with ongoing preliminary testing of antigen LFTs. A Direct LAMP pilot was underway in Greater Manchester and cases were being sought for the LamPORE technology. It was noted that supplies (kits, machines, consumables and digital infrastructure) needed to be expanded urgently. The main challenges to scaling up were to be provided for the next meeting, together with a clear set of requests for the Prime Minister to make in a roundtable to industry. Baroness Harding said that she was working on indicative costs and that

HMT had proposed a solution on its spending approvals with work underway on CO approvals.[277]

4.250. As explained above, ultimately, as a result of the asymptomatic testing pilots and the entrance of antigen LFTs into the market, HMG strategy moved away from the use of antibody LFTs and Cabinet Office officials supported DHSC in cancelling the Abingdon Health contract.

Operation Moonshot

4.251. By August 2020, Test and Trace had evolved its approach to testing, in particular to try and capture asymptomatic people and persuade them to isolate, thus lowering the reproduction rate ('R') of the virus without the need for lockdowns or other social distancing measures. The proposal was to use lower sensitivity tests on these subjects, and confirm positive results with higher sensitivity PCR tests. An initiative, sometimes codenamed "Spitfire", was proposed with ambitious targets to test the whole population weekly.[278] This initiative later became known as 'Operation Moonshot'.

4.252. Building on their work on asymptomatic and mass testing technologies, the commercial testing team in DHSC obtained a comprehensive list of testing suppliers from the Rockefeller Foundation in the US (following a meeting between Will Warr (No.10 special adviser for Health), Dr Jandziol and scientists from the Rockefeller Foundation).[279] This list contained details of suppliers with technology that might be suitable for use in a mass testing programme. This list was screened by technical and commercial experts, and many of the suppliers were contacted to obtain further details of their product offer.[280] A number of potential suppliers of antigen LFTs were on the Rockefeller Foundation list. Other suppliers were contacted based on the work that Test and Trace had already done on asymptomatic testing, such as the LAMP pilot mentioned in paragraph 4.223.

4.253. On 11 September 2020, the Prime Minister chaired a meeting on testing. He stressed the need for a continued push for UK manufacture of as much of the supply chain as possible. After the meeting the Prime Minister raised the point made

[277] GRW/280 - [INQ000233945], GRW/281 - [INQ000478821]
[278] Agenda of 5 August 2020 meeting with Prime Minister GRW/282 - [INQ000496730]
[279] GRW/283 - [INQ000497267]
[280] Supplier decisions were made in three stages: 1) initial information was obtained from suppliers; 2) technical information was reviewed by the scientific team, test kits were validated and preliminary commercial and manufacturing assessment was undertaken; and 3) a final evaluation was undertaken by a decision roundtable. Documentation on the Design Authority Review is held by DHSC

by the CEO of Roche that the UK was occasionally slower than other countries in processing commercial deals. The Prime Minister requested tracking of the major purchase orders and reporting on where any blockages were with suggestions as to how decision making could be sped up. It was suggested that Lord Bethell had agreed to chair a daily meeting to clear outstanding commercial agreements.[281] It was subsequently confirmed by NHS Test and Trace that Lord Bethell had stepped in to support those commercial processes.[282]

4.254. In September 2020, Operation (or Project) Moonshot was officially launched, to run within the existing Test and Trace infrastructure, under the leadership of SRO Alex Cooper (DHSC). Jacqui Rock remained accountable for all commercial activities in support of Operation Moonshot. In summary, Operation Moonshot had two key areas of commercial activity: (i) to identify and purchase suitable testing technologies to enable establishment of mass testing, including the logistics and operational scale up to support testing at this scale; and (ii) establish testing manufacture on mass scale in the UK both to establish sovereign capacity and to channel some of the testing budget to UK jobs and businesses.

4.255. As market engagement with potential suppliers progressed, Operation Moonshot prioritised candidate LFTs based on technical specifications, suitability, effectiveness, and ability to deliver testing capacity at scale. PHE had established a test facility at Porton Down which used deactivated virus to test the sensitivity and specificity of LFTs. The validation performed by PHE was necessarily independent of the project and comprised a three-stage process. Provisional validation was granted if the LFT passed 'stage 3a' validation, although the LFT had to pass a further, field-based assessment in order to receive full validation. Three LFT tests passed the validation process and by late September/early October 2020 initial contracts had been negotiated with all three suppliers. Details of the Porton Down test protocol were published on gov.uk by DHSC and PHE.[283] In addition, devices needed to have MHRA approval which included particular use cases, or a specific easement (for example covering home use of Lateral Flow Tests).

4.256. These three suppliers were:

4.256.1. Abbott Panbio, 11 September 2020. This was a £44m contract for the purchase of 1 million units of COVID-19 Antigen Rapid Test Devices

[281] GRW/284 - [INQ000471027]
[282] GRW/285 - [INQ000471026]
[283] GRW/286 - [INQ000496202]

(LFTs) with the option to purchase a further 10 million units together with related logistics services.[284]

4.256.2. Innova, 17 September 2020. This was a £103.6m contract for the purchase of 18 million units of Innova SARS-Cov-2 Antigen Rapid Qualitative test kits (LFTs) and related logistics services.[285]

4.256.3. Tanner Pharma (distributor of LFTs manufactured by Orient Gene), 5 October 2020. This was a £10m contract for the purchase of 2 million Coronavirus AgRapid Test Cassettes (LFTs) and related logistics services.

4.257. As with other elements of the testing programme, LFTs were bought on behalf of the whole of the UK (see earlier paragraph 4.183).

4.258. At a meeting with the Prime Minister on 2 October 2020 it was agreed that lab capacity for end point PCR tests would be ramped up and that all available global stock of LFTs, approximately 180m tests, should be purchased immediately.[286] The commercial testing team requested an extension over the weekend. During this time they engaged appropriate legal support, expedited the business case and ministerial submission and led negotiations to drive down costs for the expanded volume commitments.

4.259. As a result of this decision, further contracts were placed with the three successfully validated LFT suppliers:[287]

4.259.1. Abbott Panbio - A further £120m contract was signed on 7 October 2020 for 30 million tests.

4.259.2. Innova - A further £496m contract was awarded on 6 October 2020 for 156m tests. Additional volume was secured from Innova through a mixture of contract extensions along with a new contract in January 2021.

4.259.3. Tanner Pharma (distributor for manufacturer Orient Gene) A further £148.5m contract was finalised on 9 October 2020 for the purchase of 37.5 million tests and related logistics services. On 17 November 2020,

[284] GRW/287 - [INQ000480129]
[285] GRW/288 - [INQ000480130], GRW/289 - [INQ000513016]
[286] GRW/290 - [INQ000477942]
[287] GRW/291 - [INQ000480131], GRW/292 - [INQ000480132], GRW/293 - [INQ000513017]

a variation under the original contract was made to extend the volumes.

4.260. Baroness Harding's office responded on the direction to purchase those LFTs setting out further detail of the number of units purchased to date from those available for purchase. It is recorded that confirmed or draft contracts were in place for 254.5m antigen tests.[288]

UK testing manufacture

4.261. At the same time as purchasing a large volume of antigen LFTs from overseas, a decision was made to launch a project to boost UK manufacture of LFTs, both to establish sovereign capacity for strategic reasons and to channel some of the LFT budget to UK jobs and businesses.

4.262. A manufacturing executive with private sector experience was appointed to run the project, with commercial support from Chris Hall (formerly my deputy as GCCO). The project team examined the UK provider market with the aim of building manufacturing capacity. This was partly to give some resilience through sovereign capacity, and partly to generate cost leverage when buying from overseas. A number of UK firms had the necessary test design capability and some had previously offered antibody lateral flow tests. Some of these firms had spun out of Medisense, one of the first diabetic test strip manufacturers in the UK. I had previously run a key supplier to Medisense, which potentially built confidence that we were serious about our scale-up ambitions. From September 2020 UK firms were offering candidate antigen lateral flow tests for evaluation.

4.263. Manufacturing capacity in the UK was low compared to China and other Asian countries. It was estimated that total UK capacity could make 0.4m tests/day. DHSC set a target of making 2m tests/day in the UK, to be achieved in the first quarter of 2021. This was a small proportion of the overall target for Operation Moonshot, which was originally 10m tests/day (see paragraph 4.251 above).

4.264. A valuable focus for both design and manufacture of these tests was provided by the Rapid Antigen Test Consortium, a supplier forum convened by Professor Chris Molloy of the Medicines Catapult.

4.265. Anticipating that viable designs would sooner or later be approved by MHRA and PHE Porton Down, Chris Hall started to acquire the machines that would be

[288] GRW/294 - [INQ000471029]

required to manufacture the possible designs, as these represented long lead items for a successful project. The project team also purchased automation equipment to take the finished test strip and assemble it into the cassette. A prototype assembly machine was being developed for one of the candidate manufacturers. It was decided to accelerate this development and licence the design to build up to 20 similar machines using production engineering specialists. Over the period September 2020 to January 2021 approximately £80 million was spent to acquire machines and make other relevant pre-purchases. Doing so before a design was approved represented a risk, but the judgement was that a counterbalancing risk was that, as with other niche high precision equipment, other countries would acquire all the capacity first, shutting the UK out of LFT manufacture.

4.266. It was judged that building capacity at an established manufacturer stood a higher chance of success than going to another company which had never made LFTs. Manufacturing contracts were let using direct awards under Regulation 32 on an open-book basis that would pay the manufacturer on a per-unit basis but allow DHSC to advance some funds to enable investments before committing to manufacturing volumes.

4.267. Starting in December 2020, DHSC contracted with Omega Health, Global Access Diagnostics, and Surescreen Diagnostics for the manufacture of LFTs. These three production sites were chosen to make sure that enough capacity was available to meet DHSC's targets. An identical two-stage contract was agreed with each supplier. This contract was developed from the mid-range model services contract (see paragraph 3.39) by TLT law firm under GLD's supervision. The first stage allowed DHSC to make upfront payments for (for example) site preparation and gave DHSC an option to buy devices at a pre-agreed price. This price did not include amortisation of the upfront costs that Government had funded, which were effectively treated as a prepayment.

4.268. Although around 20 UK firms had offered LFTs for evaluation, by the end of December 2020, the only part-validated LFT belonged to Surescreen Diagnostics. The DHSC contracted with Surescreen to pre-purchase materials in anticipation of Surescreen's passing stage 3a of the Porton Down Validation process.

4.269. On 15 January 2021, DHSC entered into a £55 million production contract with Surescreen as the LFTs had passed the full PHE validation process including limited

field trials.[289] Initially Surescreen was manufacturing 1 million LFTs a week, which increased to up to 2 million a week in April 2021. Deliveries to DHSC started on 14 January 2021.

4.270. It was more challenging to start manufacturing at the other two candidate sites, Omega Diagnostics and Global Access Diagnostics. This was because the LFT product earmarked for manufacture at these sites repeatedly failed to pass PHE's validation, either because of kit failures or insufficient sensitivity. These sites were used for a limited amount of secondary manufacture of the Surescreen product (cassette assembly and packing) but the increasing capacity to undertake this work at the Surescreen sites quickly removed the need for this off-site assembly. While the value of this work did not fully justify the £2m investments in each site, these sites were, however, in a position to increase production as and when a suitable LFT design became available.

4.271. Helped by Government investment, including £2m for site preparation and advance recruitment of staff, and deployment of some of the Government-purchased production machinery, Surescreen's manufacturing capacity increased to up to 5 million LFTs a week in May 2022.

Outcome

4.272. On 4 April 2020[290] the Secretary of State for Health and Social Care set out the challenge and the level of expertise that was needed to deliver a comprehensive, nationwide Testing Programme for COVID-19.

4.273. Cabinet Office commercial experts supported across all pillars of the testing strategy and provided capability and capacity to the team through knowledge of: testing supply markets; public procurement regulations; commercial best practice in the public sector; and appropriate public sector governance processes. The Cabinet Office expertise provided a level of commercial rigour to the programme to implement a range of contracts for goods, services and manufacturing, including for some products that had never been bought before.

4.274. Key programme achievements delivered via commercial contracts were;

4.274.1. 100,000 tests per day by the end of April 2020 which was delivered in just six weeks from the programme starting;

[289] GRW/295 - [INQ000497270]
[290] GRW/231 - [INQ000106325]

4.274.2. 200,000 tests per day by the end of May 2020;

4.274.3. 500,000 mass population testing target achieved by the end of October 2020;

4.274.4. Initiating and leading the pilot that proved rapid low sensitivity testing methodologies to detect COVID-19 in asymptomatic individuals who posed an infection transfer risk;

4.274.5. Capacity set up to manufacture in the UK 1 million LFTs in January 2021, increasing to 5 million LFTs being delivered to the NHS distribution centre every week by May 2022; and

4.274.6. Identification of new testing technologies that ensured the UK was able to diversify its supply chain and expand the number of range of tests offered.

Handover

4.275. The Cabinet Office commercial team was in the Testing Programme from the start and so possessed detailed corporate memory of the testing programme itself, including how testing strategy had evolved over time, and lessons learned from contracting for new, innovative requirements during a pandemic. This concentration of knowledge represented a risk and a more durable and sustainable solution would be required for Test & Trace Commercial as it transitioned into a more business as usual environment.

4.276. Upon appointment of Ms Rock in August 2020, Dr Jandziol and other senior leaders from CTT began to discuss handover planning and long-term resourcing arrangements. CTT agreed a phased exit with resources rolling off gradually as long-term replacements were identified, to ensure risks could be managed appropriately.

4.277. Throughout August and September 2020, CTT led onboarding and induction sessions for replacement resources (both civil servants and consultants) to ensure staff were appropriately briefed and corporate knowledge was transferred. This covered detail on specific testing workstreams, as well as upskilling on public procurement regulations and Test & Trace approvals processes.

4.278. The resulting commercial organisation under Ms Rock continued to support the delivery of testing objectives throughout the pandemic. Knowledge transfer left this

team with the necessary corporate knowledge, market knowledge and commercial expertise to maintain delivery against daily testing targets as well as continue to scale up provision of testing (particularly lateral flow testing) as required throughout the remainder of the pandemic.

iii) Personal Protective Equipment (PPE)

Introduction

4.279. As with Test and Trace above, the Cabinet Office did not have a formal contracting role for the procurement of PPE during the pandemic. However, the Cabinet Office did have a role primarily in providing expert resources which set up and ran the PPE Buy Cell (explained below) under DHSC's governance. Other members of the Cabinet Office volunteered to work in the PPE Buy Cell, as did staff from other government departments and public bodies.

4.280. This role emerged from the Cabinet Office offering its expert commercial resources to help Supply Chain Coordination Ltd ("SCCL") (see below) and DHSC. The following introduction explains this context.

4.281. The NHS Supply Chain was set up in 2006 to provide goods to the NHS. In 2018, DHSC established SCCL to manage the NHS Supply Chain. In 2019, pre-Pandemic, the c.200 NHS Trusts and Foundation Trusts ("NHS Trusts") spent around £146m on PPE, of which £61m was purchased by the NHS Supply Chain.[291]

4.282. The rest (c.£85m) of the PPE purchased by NHS Trusts in 2019 was purchased from other central buying organisations and from suppliers. At the start of the pandemic, there was no centralised list of suppliers of PPE to the NHS.

4.283. Pre-pandemic, other health and social care organisations such as care homes, community care providers, GP practices and pharmacies (of which there were tens of thousands) were responsible for sourcing their own PPE primarily from independent wholesalers.

4.284. SCCL purchased PPE via a network of UK-based and international manufacturers and wholesalers, often through long-term framework agreements. A feature of the pre-pandemic procurement of PPE by SCCL and Trusts was that their direct contractual relationships were largely with distributors or agents in the UK. There was little direct engagement with, or knowledge of, the full supply chain, most of which was overseas.

4.285. Apart from the pandemic stockpile maintained by DHSC, at the start of the pandemic, there was no central record of what existing stocks of PPE were held by each Trust. The pandemic stockpile was in "deep storage" in a warehouse in the

[291] GRW/14 - [INQ000477966] - Good Law Project EWHC 46

north-west, rather than in a distribution warehouse.[292] The pallets were stacked so that they were not immediately accessible, and pallets needed to be moved to a distribution centre so that loads could be broken up to send to individual hospitals and other customers. It is my understanding that some of the pandemic stock was found to be out-of-date and therefore unsuitable or requiring re-certification before it could be used.[293] The Cabinet Office team managing the PPE Buy Cell was not aware of these issues until after July 2020, when the period of Cabinet Office direct engagement in PPE buying had ended.

4.286. From February 2020, as the pandemic spread worldwide, demand for PPE surged dramatically. It was forecast[294] that the nature of the COVID-19 disease and its possible extent would greatly increase the demand for PPE in the NHS and the social care sector.

4.287. In February 2020, SCCL was instructed by DHSC to increase its purchasing of PPE.

4.288. In March 2020, SCCL received orders from Trusts for over 400m items of PPE at a cost of c.£50m. This compared to an average month in 2019 when comparable figures were 200m items at a cost of c.£5m. Demand for PPE was projected to rise even higher as the number of patients with COVID-19 increased.

4.289. At the same time, the global market for PPE was becoming overheated for two main reasons:

4.289.1. First, the worldwide demand for PPE due to the pandemic was, as in the UK, far higher than pre-pandemic. As an example of the extent of the increase in demand, Statista Consumer Market Insights estimates that 30x more face masks were sold globally in each of 2020 and 2021 than in 2019.[295]

4.289.2. Second, the main global producer and exporter of PPE was China, but it was experiencing several problems that constrained available supply:

- COVID-19 restrictions in China had led to factory closures.
- In an attempt to control quality, the Chinese authorities had

[292] GRW/296 - [INQ000477300] - The supply of PPE equipment during the COVID-19 Pandemic
[293] GRW/297 - [GWI_nn]
[294] GRW/298 - [INQ000477301] - WHO Director General's opening remarks
[295] GRW/31 - [INQ000471055]

restricted the number of factories allowed to export PPE.

- The transport of PPE was highly constrained. Passenger flights to China had largely stopped, meaning the holds of these flights could not be used to transport goods. Sea and rail shipment involved several weeks of delay.

4.290. The price of PPE rose dramatically due to the interplay of both these demand and supply factors.

4.291. In mid-March 2020, SCCL informed the Cabinet Office and DHSC that:

4.291.1. SCCL would be unable fully to service forecast demand from the NHS and other health and social care bodies.

4.291.2. SCCL's suppliers, who were largely wholesalers, were reporting that their own suppliers were unable to fulfil larger orders because of shortages of raw material and increased demand from other countries.

4.291.3. The pandemic stockpile of PPE (which had been first established after 2009 and based on an influenza pandemic) would be exhausted in weeks.

4.291.4. SCCL's warehouses were blocked with PPE, preventing it from getting other necessary supplies to Trusts.

4.291.5. SCCL did not have the logistics capacity to distribute the amount of PPE which was required.

4.292. In summary, SCCL did not have the resources or infrastructure to deal with offers which had already started to be received for PPE. SCCL recognised that procuring and distributing the quantities of PPE required for the pandemic would exceed the capacity of its buying team, its warehouses and its distribution channels.

4.293. In terms of the stockpiles of PPE:

4.293.1. PPE had been released from the Pandemic Influenza Preparedness Programme ("PIPP") stockpile from January 2020.

4.293.2. The separate No-Deal Brexit stockpile (primarily of gloves) which had been established was also released from around the same time.

4.293.3. The pandemic stockpile contained relatively few gowns, as it was originally thought that gowns would not have been required if the disease outbreak had been the predicted influenza.

4.293.4. As far as the Cabinet Office understands, the advice on what should be held in the stockpile (while still for influenza) was changed in 2019 by NERVTAG[296] and a suitable specification for gowns was drawn up by November 2019. Market research was being done in advance of a procurement for the stockpile but plans for purchasing were interrupted by the pandemic.

4.293.5. Cabinet Office was informed about the stock situation including the pandemic stockpile and "Business as Usual" stock held in SCCL's distribution centres in an email sent by Alan Wain, Chief Operating Officer of SCCL on 15 March 2020.[297] The Cabinet Office does not hold a contemporary record that discusses either distribution difficulties with the PIPP stock or any deliveries from this stock to China.

4.294. On 16 March 2020, Jin Sahota, the Chief Operating Officer of SCCL, proposed that Cabinet Office resources (which had been offered to assist DHSC and SCCL) be allocated to explore manufacturing PPE and sourcing it from alternative suppliers (i.e. other than currently known SCCL suppliers).[298] On 17 March 2020, I exchanged emails with colleagues in the DHSC, CCS, SCCL and NHS E/I to determine the best way to deploy extra GCF resources to obtain more PPE.[299]

4.295. The problems faced by existing suppliers were confirmed by a series of calls with SCCL's main suppliers at the end of March 2020, which were recorded in a report dated 1 April 2020.[300] In particular:

4.295.1. Factories were already booked out until August 2020.

4.295.2. Orders were requiring large upfront payments.

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[296] NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group) is an expert committee of the DHSC. It provides scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management
[297] GRW/299 - [GWI_INQ000496689]
[298] GRW/300 - [INQ000471004]
[299] GRW/301 - [INQ000496900], GRW/302 - [INQ000496901]
[300] GRW/303 - [INQ000477920]

4.295.3. There were export bans in a number of countries, including Egypt which had been an important source of gowns to the UK pre-pandemic.

4.295.4. PPE was having to be transported by air freight to keep up with demand, as shipping took too long, but the air freight capacity was limited and expensive at this time.

4.296. Overall, there was a massive spike in demand for PPE from March 2020 driven by the global uncertainty in estimating the need for PPE combined with speculative buying (where non-healthcare purchasers bought stock with the intention of selling it on at a higher price).

The Parallel Supply Chain

4.297. Because of the increased demand for PPE that SCCL was unable to supply, DHSC decided to establish a "Parallel Supply Chain" to take over the supply and distribution of certain key items of PPE.[301] SCCL remained responsible for the procurement of other medical supplies (including other types of PPE such as foot coverings and detergent, which were not deemed to be critically short of supply) to the NHS. The team in SCCL that bought PPE was brought into the Parallel Supply Chain, which was tasked with sourcing:

4.297.1. Aprons.

4.297.2. Body bags.

4.297.3. Clinical waste bags (for a short period).

4.297.4. Eye protection (goggles and visors).

4.297.5. Face masks (Type IIR).

4.297.6. Respirators (N95, FFP2 and FFP3).

4.297.7. Hand sanitiser.

4.297.8. Gloves.

4.297.9. Gowns (which included coveralls as an alternative, once approved).

[301] GRW/304 - [INQ000512986]

4.298. The Parallel Supply Chain was responsible for sourcing the above categories of PPE for all Trusts and other health and social care bodies. The PPE procured by the Parallel Supply Chain was provided to the end users for free and was still available for free in England until the end of March 2024[302] or when stocks run out (more than half of the different items were out of stock[303]).

4.299. The Parallel Supply Chain was set up within DHSC and was part of the 'COVID-19 PPE Plan' published by DHSC on 10 April 2020.[304] The PPE Plan was requested by the Prime Minister's Office.[305] It was produced by DHSC in consultation and cooperation with the devolved administrations.[306] The PPE Plan was discussed at the HMIG on 9 April 2020 and presented to the COVID-19 Strategy Ministerial Group Meeting (9.15am) on 10 April 2020[307] before it was published on gov.uk later that day.

4.300. The goal of the Parallel Supply Chain was to obtain as much of the PPE items set out above as could be obtained to supply the entirety of the health and social care sector.

4.301. The Parallel Supply Chain comprised several different elements:

4.301.1. The "Buy" team (or "PPE Buy Cell") was responsible for the procurement of PPE, including producing a sourcing strategy (the first draft was produced on 11 April 2020[308] and the final version was issued on 29 May 2020[309]) ("the PPE Buy Cell").

4.301.2. The "Make" team was responsible for producing PPE in the UK.

4.301.3. The "Move" team was responsible for establishing the supply and distribution networks.

4.301.4. The Communications or "Comms" team was responsible for external communications (outside the Parallel Supply Chain).

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[302] GRW/305 - [INQ000477955]
[303] GRW/306 - [INQ000477954]
[304] GRW/307 - [INQ000050008]
[305] GRW/308 - [INQ000477921]
[306] GRW/309 - [INQ000088660]
[307] GRW/310 - [INQ000088663]
[308] GRW/312 - [INQ000480113]
[309] GRW/311 - [INQ000330862]

4.302. The PPE Buy Cell interfaced with the "Make", "Move" and "Comms" teams on a daily basis, but these teams were separate organisations with separate reporting lines. The "Make" team reported initially to Andy Flockhart of Deloitte, then from May 2020 directly to Lord Deighton (see below). The "Move" team reported to Brigadier Phil Prosser from the MoD.

4.303. The Cabinet Office was not directly involved in the establishment or management of the "Make" team, the "Move" team or the "Comms" team[310]. A commercial expert (Peter Stanton-Ife from CTT) was later provided by the Cabinet Office to assist the "Make" team, which was established before CTT staff formed the PPE Buy Cell on 21 March 2020. As stated above, the 'Make' activity was led by a Deloitte consultant and staffed by a Deloitte team until Gil Staeyart (brought in from Adidas) took over management on around 4 May 2020, and the team was then restaffed by staff recruited by Lord Deighton.

4.304. The distribution activity, including liaison with the devolved administrations (for e.g. inter-nation stock transfers or 'mutual aid') was undertaken by the "Move" team under the direction of DHSC with significant assistance from the Armed Forces, and with no Cabinet Office involvement.

The PPE Buy Cell

4.305. As a department, the Cabinet Office did not have a formal contracting role in the PPE Buy Cell. No Cabinet Office official had the authority to approve or sign contracts. The formal contracting role was with DHSC. Jonathan Marron, the Director General for Public Health in DHSC, was the Senior Responsible Officer for the PPE Buy Cell. David Williams, the Second Permanent Secretary at DHSC, was the Accounting Officer.

4.306. However, Cabinet Office officials played important roles in the PPE Buy Cell. In particular, on Saturday 21 March 2020, a small number of Senior Civil Servants from the Cabinet Office, all Deputy Directors (i.e. commercial specialists) in the CTT, were assigned to DHSC to work under Jonathan Marron and Emily Lawson. Their task was to design, establish and manage the operations of the PPE Buy Cell, which was set up from scratch:[311]

4.306.1. Andy Wood was the team leader of the PPE Buy Cell.

[310] Consequently no notes or minutes regarding the formation of the teams are held by Cabinet Office
[311] GRW/313 - [INQ000478786]

4.306.2. Jo Newman was the operations manager for the PPE Buy Cell. One of her roles was to allocate people to tasks within an agreed structure.

4.306.3. Richard James initially led the liaison with, onboarding and integration of the SCCL team with the rest of the PPE Buy Cell. In early April 2020, he handed this responsibility over to Darren Blackburn and was then responsible for the design and communication of the PPE Buy Cell's processes and controls, from initial contact with prospective suppliers to delivery into the warehouse (i.e. excluding the logistics of delivery to end customers)

4.306.4. Darren Blackburn managed the processing of opportunities.

4.306.5. Mark Towey assisted with the processing of opportunities. He left the PPE Buy Cell on 10 April 2020.

4.307. Following the assignment of these CTT staff, the PPE Buy Cell started its buying operations with a briefing from John Manzoni and Jin Sahota on Saturday 21 March 2020.

4.308. There was no formal letter of engagement for the assignment of the CTT staff for the PPE Buy Cell initially because it was more important to get the cell set up, and later because the Cabinet Office had decided not to recharge DHSC for the time they spent.[312] As explained in Section C above, CTT staff are normally charged out to other departments on a day rate basis under a formal letter of engagement.

4.309. All these staff reported to Jonathan Marron and Dr Emily Lawson, the Chief Commercial Officer of NHSE/I, who were the joint leaders of the Parallel Supply Chain. The overall management and governance of the PPE Cell was therefore provided by DHSC.

4.310. While assigned to DHSC, the Cabinet Office officials in the PPE Buy Cell would also report back (at times daily) to Janette Gibbs as their supervisor and the acting Director of the CTT. To ensure I remained aware of the activities of the Cabinet Office staff, I asked the staff assigned to DHSC to update me regularly on what they were doing, as an informal report.[313]

[312] This applied from March to June 2020. CTT did charge DHSC for two team members supplied in July 2020, for whom there was an engagement letter.
[313] GRW/314 - [INQ000478813], GRW/315 - [INQ000496712], GRW/316 - [INQ000496723] are examples

4.311. On 17 April 2020, the Secretary of State for Health and Social Care appointed Lord Paul Deighton, a member of the House of Lords, as his Advisor on PPE in DHSC. This was an unpaid position. Lord Deighton's initial appointment was to lead the efforts of the PPE Make Cell.[314]

4.312. Later Lord Deighton's role was expanded to cover all PPE acquisition activity. On 27 April 2020, Lord Deighton was briefed on the PPE Buy Cell by Andy Wood and Chris Hall (a Director from the CCT and my deputy). From the beginning of May 2020, Lord Deighton chaired the Oversight Committee for the PPE Buy Cell.[315] On 12 May 2020, the Cabinet Secretary formally wrote to Lord Deighton confirming his appointment to lead the "PPE Taskforce" (aka the Parallel Supply Chain).[316]

Staff for the PPE Buy Cell

4.313. Further staff for the PPE Buy Cell, particularly caseworkers, were recruited by:

4.313.1. Asking for volunteers from the commercial teams in various government departments, including DHSC, NHS England and NHS Improvement, the Cabinet Office (from other teams in the CCT, not just the CTT), the Ministry of Defence, the Ministry of Justice and the Department for Education. The volunteers all had commercial experience but very few had bought medical supplies or PPE before. The staff from the Cabinet Office who volunteered and carried out operational roles, other than the management roles described above, in the PPE Buy Cell were primarily in the "Opportunities" teams as explained below.

4.313.2. Engaging specialist external procurement consultants from Efficio Consulting, Deloitte, Baringa Management Consulting and 4C Associates.

- Efficio Consulting and 4C Associates were engaged by DHSC. Both of these consultancies are procurement specialists, although they were not employed to make procurement decisions. Efficio provided analytical support including the formation of buying targets, reporting to DHSC. 4C were retained to assist with transition from the initial organisation of the PPE Buying Cell to a

[314] GRW/317 - [INQ000198247]
[315] GRW/318 - [INQ000477266]
[316] GRW/319 - [INQ000477929]

more permanent PPE buying organisation that was expected to last into 2021, in which role they reported to Chris Hall of the Cabinet Office.

- Consultants from Deloitte (engaged by DHSC) initially led and were subsequently part of the China Buy team (as well as their role in the "Make" operation). As stated in paragraph 4.359.2, the China Buy team was initially led by an NHS employee and later by Michael Jordan from CTT.

- Baringa was engaged by the Cabinet Office under its pre-existing co-sourcing agreement (see paragraph 4.316). Baringa worked alongside the CTT staff and took roles as caseworkers, in support of formation of the PPE Buy Cell organisation and subsequently the procurement strategy. The Baringa team reported to Jo Newman of the Cabinet Office in her role as Head of Operations for the PPE Buy Cell.

- The fees for all of these consultants (except Baringa) were paid by DHSC. Baringa was paid a total of £570K (ex. VAT) for its work on PPE buying by the Cabinet Office, and this bill was passed through to DHSC.

- The consultants working in the PPE Buy Cell did not have the authority to enter into contracts or make procurement decisions, except under the direction of team leaders who were either civil/crown servants or contractors directly employed by the Cabinet Office or DHSC.

4.314. Prior to COVID-19, CTT already had call-off contracts for staffing in place via the Crown Commercial Service (CCS) Management Consultancy Framework 2. In 2019, CTT undertook a further competition under the terms of this framework, issuing an invitation to tender to 22 suppliers including SMEs and large consultancies with the relevant commercial skills. Following the tendering process, four call-off contracts were awarded in October 2019, including one to Baringa, contracting through Bramble Hub. They were chosen as knowledgeable and expert partners with the right skills and experience to deliver value for money across a number of CTT projects.

4.315. The call-off contracts were put in place for 24 months, with the option to extend by a further six months. The contract value was approved through the Consultancy Controls process on 11 September 2019. The four consultancies were awarded work by CTT on a rotational ('cab-rank') basis. In certain instances, such as where there were urgent requests, or where there was a significant imbalance of work, by value, between the consultancies, or if the consultancy was unable to provide suitable candidates with the required skills and experience within a reasonable timeframe, the rotation could be changed.

4.316. In March 2020 it was Baringa's turn to receive the request to provide additional resources to supplement the CTT team working in the PPE Buy Cell. This 'co-sourcing' vehicle was used as more commercial resources were needed for the PPE activity and CTT staff were fully deployed. The Baringa consultants worked in the various PPE workstreams (as other consultants and civil servants did) paid for by CTT, with the costs subsequently transferred to the DHSC. This was contracted in a 'back-to-back' arrangement by two separate documents: a) a Statement of Work (SoW) between CTT and Bramble Hub (Baringa) and b) Engagement Letters between DHSC and CTT to cover the Bramble Hub (Baringa) costs.[317]

4.317. The two Statements of Work were scoped with named resources and capped costs and were delivered for work commencing in March 2020 in the following areas:

4.317.1. PPE Cell Mobilisation and Process Mapping;

4.317.2. Offers Database;

4.317.3. Sourcing Strategy;

4.317.4. Rapid Response Team;

4.317.5. Category Organisation Implementation; and

4.317.6. Handover activity completing in July 2020.

4.318. The organisation structure for PPE Sourcing is exhibited showing that the Baringa resources reported to Jo Newman.[318] Jo had been deployed from CTT into the PPE Head of Operations role reporting into Emily Lawson, the PPE Lead for DHSC. Jo Newman was also the CTT Contract Manager for the Statement of Works. The

[317] GRW/320 - [INQ000497229], GRW/321 - [INQ000497265], GRW/322 - [INQ000496758], GRW/323 - [INQ000496745]
[318] GRW/324 - [INQ000496710]

Baringa costs were capped and Jo Newman worked with Sarah Ashley, the Baringa lead, to monitor resources deployed into the various workstreams within the cost cap. On a day-to-day basis the Baringa consultants took instructions from the relevant workstream leads.

4.319. The senior staff of the PPE Buy Cell (members of the CTT) and early volunteers (c.20 staff) initially worked in DHSC offices, such as Skipton House near Elephant and Castle, for the first 2 or 3 weeks of the deployment. After that the decision was made to generally work from home given there was limited space and the risk of getting ill. There were still some meetings in person from time to time.

4.320. The PPE Procurement Cell had almost 150 people working on it by 1 April 2020[319], 508 people by 19 May 2020[320] and then 450 people by 2 June 2020.[321] These people were located across the UK and working primarily remotely (over 400 staff) in virtual teams. Given that they came from a variety of units, they did not know each other and had rarely, if ever, worked together before.

4.321. Of the 508 people working in PPE Procurement Cell by 19 May 2020, 52 were from the Cabinet Office.

Demand for PPE

4.322. It was the responsibility of the DHSC to assess and then determine the demand levels that should be procured. The Cabinet Office was not involved in assessing demand, although Cabinet Office staff worked with consultants from Efficio to produce a buying plan from 26 April 2020 as described from paragraph 4.333 below. Some demand information (regarding days of demand in stock or expected) was later incorporated into the COVID-19 Dashboards produced initially by the Civil Contingencies Secretariat and later by the COVID-19 Taskforce.

4.323. That said, the position in the first few weeks of the PPE Buy Cell was that the demand was so great and immediate that all available items needed to be purchased (subject to meeting the specification, price, due diligence etc).

4.324. I have been given to understand that the demand for PPE were initially (i.e. prior to the McKinsey model which I explain below) assessed by DHSC and the NHS, considering the requests received from health and social care organisations to (i)

[319] GRW/325 - [INQ000477950]
[320] GRW/326 - [INQ000477253]
[321] GRW/327 - [INQ000477276]

SCCL, (ii) a hotline, (iii) local resilience forums (LRFs), and (iv) eventually to an ordering portal set up with eBay.

4.325. The priority items were communicated to the PPE Procurement Cell at the daily early morning meeting led by Jonathan Marron and Dr Emily Lawson.

4.326. In April 2020, the priority items were gowns and type IIR face masks. Later gloves, aprons and FFP3 and FFP2 respirators were added to the list.

4.327. From late April 2020, the demand for PPE was calculated by a model called "the McKinsey model" produced by McKinsey consultants working for DHSC. This model extrapolated PPE demand from the number of patient interactions predicted as the caseload grew:

4.327.1. The model was based on the SAGE Reasonable Worst Case Scenario (RWCS), which forecast the caseload week by week through Wave 1 in Spring-Summer 2020 (and into Wave 2).

4.327.2. Different types of interaction required different types of PPE; for example nursing a seriously ill patient in an ICU required respirators, full gowns, eye protection and gloves.[322]

4.328. Again this process and the resultant figures were managed by DHSC.

4.329. The figures were provided to the PPE Buy Cell which it used to build a Buying Plan. The full rationale behind the estimated demand figures was not provided to the PPE Buy Cell or the Cabinet Office. The PPE Buy Cell and Cabinet Office was not in a position to disagree with DHSC and the NHS on what PPE was required. Only in one rare instance was there push back by the PPE Buy Cell when there was a request to buy 90,000 body bags a month. I personally pushed back on this demand, raising the question that this would have to be based on expected deaths of over 1 million in a year. Buying Plans added estimated allowances for non-delivery or delivery of non-compliant products to the DHSC's demand calculations (see paragraph 4.350).

4.330. The PPE Buy Cell ultimately had two goals. It had to obtain, ready for distribution, enough stock of each key item to satisfy:

[322] GRW/328 - [INQ000477957]

4.330.1. Wave 1 demand (Spring-Summer 2020). This was in part replenishing the pre-pandemic stock which had been consumed in the early weeks of the pandemic .

4.330.2. By November 2020, four months' demand according to the RWCS for Wave 2.

4.331. The RWCS scenario predicted excess deaths of 520,000 due to COVID-19 within 3 months. The PPE Buy Cell was therefore buying PPE for that severity of pandemic and level of hospitalisations. It also was not known, and could not be predicted, when a vaccine would be available. During the initial peak phase of PPE buying, this RWCS model did not take into account the effect of the lockdown and other measures. Once manufacturer's initial stocks were exhausted, purchases for PPE were largely buying production slots for stock which had not yet been produced. Allowing time for shipping as well, this meant that PPE could take 2 or 3 months to arrive in the UK from when it was ordered. As a result of this lag, it was necessary to buy sufficient PPE to handle the demand that was expected to be seen at the time of eventual delivery, some time in the future, with all the unknowns and uncertainties that involved particularly at the start of the pandemic, not the demand pertaining at the date of order. Inevitably these projections were only estimates.

Buying targets

4.332. The demand figures obtained from the McKinsey model were translated into a purchasing model, or "buy signal", by the PPE Buy Cell. In particular, Efficio, the procurement consultants engaged by DHSC, produced a purchasing model which set out the buying targets for each type of PPE, such as aprons.

4.333. The PPE Buying Target spreadsheet was first issued (after an earlier preview on 26 April 2020) on 3 May 2020,[323] and regularly updated.[324]

4.334. Prior to this point, the PPE Buy Cell's targets were based on informal numbers it was provided with such as "we need 400,000 gowns a day" based on anticipated (not actual) usage.

[323] GRW/329 - [INQ000478804]

[324] GRW/330 - [INQ000478808], GRW/331 - [INQ000478810], GRW/332 - [INQ000478811]

4.335. The buying targets adjusted the forecast demand from the McKinsey model (version dated 30 April 2020) to take account of:

4.335.1. "Shrinkage" or an estimate of items purchased which would not be acceptable and would not be delivered. The shrinkage percentage varied for different items of PPE and for different buying channels (see paragraph 4.350).

4.335.2. "Leakage" for NHS Trusts and other organisations sourcing their own PPE directly, not through the central supply programme run by the PPE Buy Cell. This was calculated to be 5%.

4.335.3. The PPE Buying Target model gave:

- A week-by-week view of incoming stock based on (1) orders already placed and (2) 'high confidence' opportunities that had yet to be contracted for.
- A comparison of the incoming stock with the demand forecast from the "McKinsey model" and the purchasing target.

4.336. The PPE Buying Target model was reviewed at least every week and sometimes twice a week by the managers in the PPE Buy Cell, such as Andy Wood and Chris Hall. This meeting set the priorities for the PPE Buy Cell, for example to concentrate on particular categories of PPE in short supply, or to deprioritise (or in some cases, stop buying) other items where the forecast stock position was healthier.

4.337. An example of the Efficio purchasing model can be seen in the 'Buy Team – Summary Strategy' issued by Efficio on 18 May 2020:[325]

4.337.1. The first two slides are a review of the procurement of the different products.

4.337.2. Slides 24 to 78 set out the detail for each product (e.g. gloves) of:

- The buy targets.
- Benchmark pricing.
- Spend to date.

[325] GRW/333 - [INQ000513006]

4.338. The process of using the SAGE RWCS to inform the DHSC PPE demand model to then inform the purchasing model was summarised in the 'Modelling Covid 19: Estimation errors' discussion paper. This is dated 29 January 2021 and was written for the second Boardman review, on which there is further detail in Section F.

4.339. The buying targets were based on supplying all NHS Trusts and the social care sector throughout the UK.

4.340. Following a detailed analysis by Ernst & Young of the international market for PPE commissioned by DIT,[326] from early-to-mid May 2020 the strategic approach of the PPE Buy Cell changed to focus on fewer bigger suppliers in certain markets (namely China, Thailand and Malaysia), rather than placing smaller orders with more and new suppliers. This new strategy was part of the changes implemented once Lord Deighton assumed his oversight role for the PPE Buy Cell and was presented to the Prime Minister as part of the PPE Update on 13 May 2020.[327] This strategy was also reflected in the final Sourcing Strategy prepared by the PPE Buy Cell.[328]

PPE Buy Cell: purchasing streams

4.341. The PPE Buy Cell used 4 routes to purchase the critical items of PPE for which it was responsible.

4.342. **Route 1**: PPE was procured from existing suppliers of PPE to SCCL. This procurement route was run by the pre-existing SCCL teams responsible for the items which the PPE Buy Cell had been tasked to procure. Those existing SCCL teams were integrated 'as-is' into the PPE Buy Cell. Jane Harrison of SCCL led this team, reporting to Rob Young of SCCL. The SCCL Team came within the management structure of the PPE Buy Cell from the beginning of April 2020 however it largely operated independently from the rest of the PPE Buy Cell. It followed its own procurement processes, and used SCCL systems. The rest of the PPE Buy Cell could not use the SCCL systems as it was impossible to add so many new users.

4.343. The SCCL Team sought to develop their suppliers' existing capacity and explore broader supply chains with the benefit of their suppliers' knowledge.

[326] The preliminary analysis from EY was dated 7 May 2020 GRW/334 - [INQ000477246]
[327] GRW/335 - [INQ000480119], GRW/336 - [INQ000477248]
[328] GRW/311 - [INQ000330862]

4.344. However, there were "touch points" between the SCCL Team and the wider PPE Buy Cell:

4.344.1. The SCCL Team provided the initial specifications of the PPE which was to be bought by the PPE Buy Cell. On 30 March 2020 specifications based on guidance developed by the Health and Safety Executive (HSE) and the Medicines and Healthcare Products Regulatory Agency (MHRA) on behalf of NHSE/I were uploaded to the internet[329].

4.344.2. The specifications were published to encourage more conformant offers and as part of good practice. The specifications were regularly updated and improved by DHSC over the next few weeks. The Cabinet Office did not have a role in producing this guidance.

4.344.3. The specifications for PPE were set by DHSC, as discussed below in paragraph 4.352. While some derogations were granted by regulators (as discussed in paragraph 4.354), the whole of the PPE Buy Cell (including the SCCL Team described in paragraph 4.343 above) was tasked with buying to the published specifications.

4.344.4. SCCL also had a small technical team in a unit called "Clinical and Product Assurance" (CaPA) which provided Technical Assurance for the wider PPE Buy Cell for the first few days of operations.

4.344.5. The PPE Buy Cell reported SCCL's figures for orders it had secured each day in its daily dashboard, which include figures for all buying streams. This data was gathered at around 4pm each day and sent to the NHSE/I PMO for the next day's 8.30am call (see below).

4.344.6. Individuals from the PPE Buy Cell management team met with a number of SCCL's main suppliers after a few weeks to encourage them to provide more stock. All further PPE obtained following this encouragement went through the SCCL Team buying process.

4.344.7. The PPE purchased by the SCCL Team eventually used the same logistics operation established by the PPE Move Cell for PPE purchased by the PPE Buy Cell.

[329] GRW/337 - [INQ000471052]

4.344.8. The SCCL Team attended regular team meetings with the PPE Buy Cell.

4.345. The Cabinet Office does not have direct access to the data on the purchases made by the SCCL Team. According to SCCL, the SCCL Team ordered £5.1 billion of PPE between 1 February 2020 and July 2021.[330] DHSC will have the final, complete data.

4.346. **Route 2:** an "open source" approach was used to seek offers of supply from mainly UK, and some international companies, called the "Coronavirus Support from Business Scheme". By 30 March 2020, a portal was established on the gov.uk website for businesses to make an offer to supply goods or services, including PPE by filling in a webform. This was the primary route in which the Cabinet Office was involved and is explained in more detail below.

4.347. **Route 3**: referrals were made from Ministers, MPs and Senior Officials to a 'High Priority Lane'. These companies either had already applied via Route 2 or were told to complete the webform for Route 2 as part of processing their offers. The High Priority Lane is explained in more detail below.

4.348. **Route 4:** factories and local intermediaries in China ("China Buy"). Chinese factories or local intermediaries were found by the FCO/DIT Joint Action Coordination Team (JACT) team in the Beijing embassy.

4.349. It was originally intended that a "call to arms" would be made by either Secretary of State for Health and Social Care and/or the Prime Minister, to encourage businesses to make offers of PPE via the portal (Route 2). Calls were planned for 20 March 2020[331] and 25 March 2020[332] but both were stopped at short notice. One reason for this was that many unsolicited offers were arriving, and that encouraging even more would further swamp the ability of the newly formed PPE Buy Cell to deal with them. Eventually a 'call to arms' was made in conjunction with the publication of the PPE Supply Plan on 10 April 2020.[333]

4.350. The PPE Buy Cell understood that the cheapest and lowest risk route to purchase PPE was through existing SCCL suppliers (Route 1). A supply risk adjustment was calculated for the different routes which was adjusted over time, and used in the

[330] GRW/338 - [INQ000496737]
[331] GRW/339 - [INQ000471009]
[332] GRW/340 - [INQ000471008]
[333] GRW/341 - [INQ000086580]

buying plan produced for the PPE Buy Cell by Efficio (the buying plan is exhibited at paragraph 4.352 below). In April 2020, there was 95% confidence that aprons purchased by SCCL would be delivered in the quantities and quality required by the purchase order. In contrast, the confidence for aprons procured by the PPE Buy Cell (Routes 2 and 3) and the China Buy (Route 4) was only 64%. These increased to 72% in May 2020 and 86% in June 2020.[334]

4.351. PPE purchased by the PPE Buy Cell through Routes 2, 3 and 4 was procured under Regulation 32(2)(c) of the 2015 Regulations ("negotiated procedure without prior publication"), following the guidance in PPN 01/20, because the urgency with which PPE had to be procured in the prevailing market conditions meant that the statutory minimum time limits for competitive procedures (which I explain in Section C above) could not be complied with. SCCL also used Regulation 32(2)(c) for PPE purchased by Route 1, although I assume it also used call offs under existing frameworks too. However, the fact that there was no formal competition under the 2015 Regulations did not mean that it was uncompetitive. The PPE Buy Cell was asking "is this a good price for today, compared to the prevailing market price for this product?". Running averages of prices paid for PPE were initially compiled by the Closing Team[335] and from late April 2020, were produced regularly by Efficio.[336]

Specifications for PPE

4.352. The responsibility for drawing up the Infection Prevention and Control guidance for what PPE should be used in healthcare settings lay jointly with the DHSC, Public Health Wales, Public Health Authority Northern Ireland, Health Protection Scotland, PHE and NHS England with the lead taken by the "IPC cell" convened by NHS E&I. The guidance was agreed by the Chief Medical Officers of all four nations of the United Kingdom. The guidance was translated into specifications and published on gov.uk jointly by the Cabinet Office and DHSC. The Cabinet Office had no role in setting these specifications. These specifications quoted relevant standards, which were the statutory responsibility of two bodies, MHRA (for medical devices) and HSE (for equipment impacting workforce safety). Guidance on who regulated what was published on gov.uk on 26 March 2020. As the oversight body for standards-making and enforcement in the UK, the OPSS (part of BEIS) also had a role. Any regulatory easements were the responsibility of these regulatory bodies.

[334] GRW/342 - [INQ000478818]
[335] GRW/343 - [INQ000497245]
[336] GRW/344 - [CHA_INQ000496734]

4.353. On 27 March 2020, the Economic and Business Response Implementation Group[337] noted a proposal to simplify some approval processes relevant to PPE to allow more devices into the market as long as they met safety standards. This proposal was initiated by BEIS and DHSC rather than by the Cabinet Office.

4.354. For PPE, I note below (at paragraph 4.426) how an individual liaised between the Technical Assurance team and a 'Decision Committee' with representatives from all the regulatory bodies (MHRA, HSE, OPSS) to seek derogations. Some derogations were sought and granted; for example on 26 April 2020 the Decision Committee agreed that gowns complying with the US standard AAMI level 4 could be purchased for use in NHS Wales. As described in paragraph 4.344.1 above, the first set of specifications used by the PPE Buy Cell had previously been issued to SCCL's suppliers as part of the then-current buying process up to March 2020.[338] As knowledge of the disease evolved, these specifications were changed on several occasions during the period of peak buying. The specifications and subsequent updates were published on gov.uk. Initial changes were made on 30 March 2020,[339] followed by further changes on 3 and 6 April and 5 and 11 May 2020. Changes continued to be made until 2022 and the specifications were withdrawn on 3 March 2023.

4.355. The whole of the PPE Buy Cell was tasked with buying to these specifications including SCCL team members, as stated in paragraph 4.344.3 above.

Operations of the PPE Buy Cell

4.356. There was a daily review call of the management of the overall PPE effort in the DHSC at 8.30am each morning from 27 March 2020. The leaders of each of the "Communications", "Buy", "Make", "Supply and Distribution" and "Demand Feedback" Cells reported to Dr Emily Lawson. These meetings set the key tasks on which each group would focus on that day, as well as discuss the main risks, decisions or escalations. As an example, on 12 April 2020 these tasks included identifying how to get donations to the distribution centre once the goods donated had passed technical assurance. From 28 March 2020, the readout of this call included a data dashboard showing the products which had been purchased.[340]

[337] GRW/345 - [INQ000083295]
[338] GRW/346 - [INQ000496902]
[339] GRW/347 - [INQ000339324]
[340] GRW/348 - [INQ000478785]

4.357. The readout formed the basis of the daily mid-morning meeting of the PPE Buy Cell (called the 9.30am meeting).[341] This meeting was attended by the management teams of all elements of the PPE Buy Cell. Outcomes and priorities were recorded in the meeting pack[342] which was sent to team members via email following these meetings.

4.358. This structured effort was required to ensure that people were not working on the same opportunities, which would have meant duplicating effort and other opportunities not being pursued.

4.359. The PPE Buy Cell procurement process was split into smaller tasks assigned to different teams:

4.359.1. The 'Opportunities Teams' (of which there were several) reviewed offers received by the web portal; or, in the case of the High Priority Lane team, which was one of the Opportunities Teams, offers referred to the High Priority Lane via a dedicated mailbox.

4.359.2. The 'China Team', i.e. the UK end of the "China Buy" Route 4, worked with FCO and DIT staff in the British Embassy in Beijing to identify and agree contracts for strategic opportunities to buy PPE directly from manufacturers in China. The FCO/DIT staff were diplomatic staff and trade envoys who mostly had no training or background in procuring goods, but their assistance was invaluable. The China Team was established by DHSC before the rest of the PPE Buy Cell and as a consequence the Cabinet Office was not involved in its formation. From 31 March 2020 the team was led by Michael Pace (of NHS London) and by Michael Jordan (CTT contractor) from 5 April 2020. Other members of the China team were originally drawn from Deloitte and subsequently from NHS London.

4.359.3. The integrated 'SCCL Team' sought to secure supplies from existing suppliers (i.e. Route 1 explained above).

4.359.4. The 'Technical Assurance Team' was responsible for ensuring that suppliers had provided appropriate, complete and genuine documentary evidence that the products offered would meet the technical specifications and standards and that the factories

[341] GRW/349 - [INQ000496909]
[342] See slide 5 of GRW/349 - [INQ000496909]

manufacturing the products possessed the appropriate quality certifications and export licences to supply goods to the UK. The Technical Assurance team was initially staffed and managed by the Defence Equipment and Support Organisation (DE&S), an arm's length executive agency sponsored by the MoD which delivers equipment and support services to the UK armed forces, and later augmented by NHS staff.

4.359.5. The 'Closing Team' was responsible for negotiating and concluding the contractual terms for PPE supplies. This team was also initially staffed and led by MoD DE&S.

4.360. The final contracting (and publishing of contracts) was done by DHSC, using DHSC systems and outside the PPE Buy Cell. The DHSC Finance team was responsible for arranging for payments and facilitated the Accounting Officer approval. The Finance team was managed and staffed by DHSC. No ministers were involved in the decision making. This is a standard approach where a contract does not involve a strategic relationship.

4.361. Support to these core teams was provided by:

4.361.1. The Project Management Office (PMO) in the PPE Procurement Cell which was responsible for convening regular meetings, distributing information to the other teams and reporting.

4.361.2. The 'Operations Team' which was responsible for making sure the PPE Procurement Cell had the resources needed to do its job, including recruiting (and offboarding) staff and IT support.

4.362. The benefits of this division of roles were that:

4.362.1. Those who had volunteered for the PPE Buy Cell from other departments (and did not have PPE buying experience) could be taught their role in a few hours and be productive quickly.

4.362.2. Each offer had to go through several different people in segregated teams, before a contract was signed, which reduced any risk of collusion, bias and the award of inappropriate contracts.

4.363. However, there were also downsides in practice. In particular, because each offer had to go through several different people in different teams, there was some

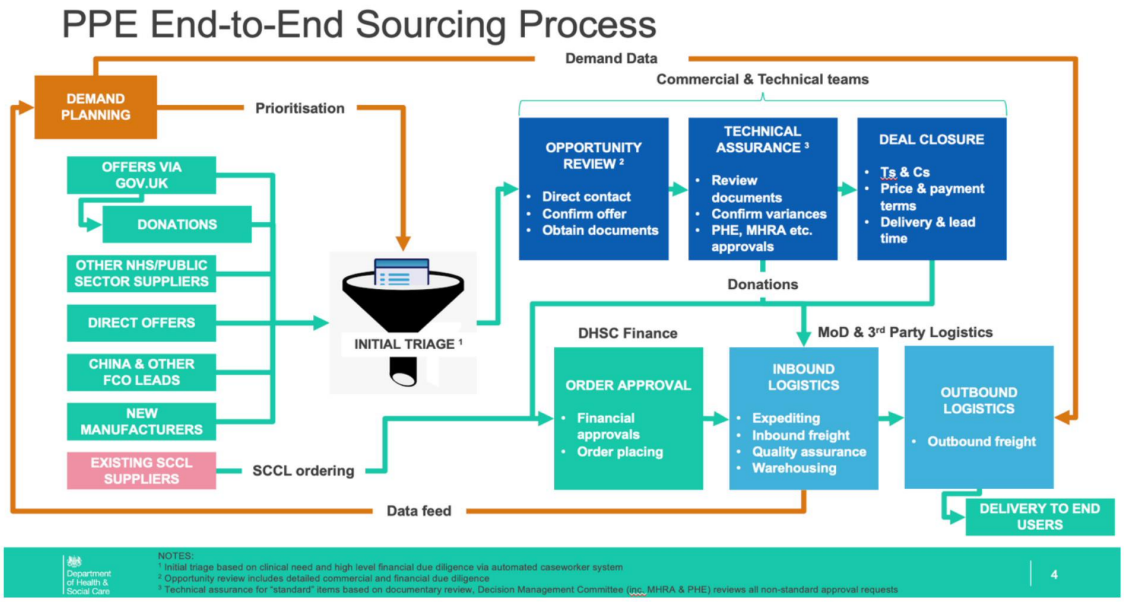
inefficiency, there was a lack of feedback loops and there were too many handovers. On reflection, a different category based structure (i.e. where specific teams focused on handling specific types of PPE) likely would have been more efficient. The PPE Buy Cell ultimately did transition to such a structure. In addition from 24 April 2020 the PPE Buy Cell also used a multi-skilled team for 'Rapid Response' cases as described in paragraph 4.471 and onwards below.

4.364. I explain the roles of the different teams in more detail below. The different stages of processing a contract by the PPE Buy Cell, from the initial offer to delivery of the PPE to users is shown on the flow chart exhibited.[343]

4.365. Only the first 3 stages were part of the PPE Buy Cell. The first stage (the Opportunity Team) was directly managed by Darren Blackburn of CTT and had operational staff from the Cabinet Office, as well as many other public servants. In addition the HPL team (a special Opportunities Team, managed by Max Cairnduff of CTT), and the China team (described in paragraph 4.385 and onwards, and managed by Michael Jordan of CTT) were also managed by Cabinet Office officials. The Technical Approval and Closing Team stages had team leaders and operational staff primarily from the MoD, but formed part of the wider PPE Buy Cell led by Cabinet Office CTT staff assigned to DHSC. Cabinet Office officials also assisted DHSC in setting up the Contract Management function.

4.366. The overall process flow in which the PPE Buy Cell sat is shown by the following diagram from a presentation prepared by DHSC in April 2020:[344]

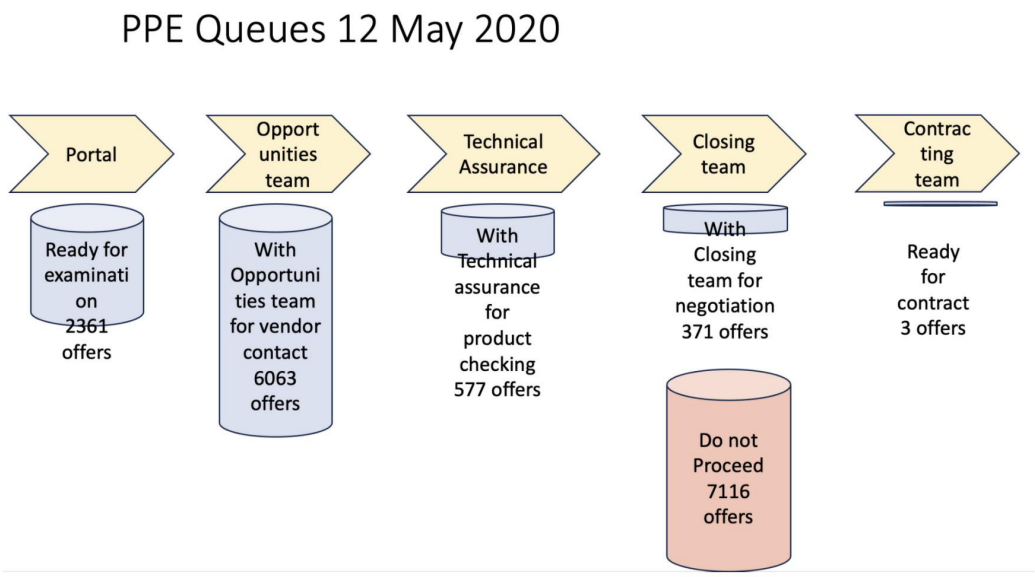
[343] GRW/350 - [INQ000496752]
[344] GRW/351 - [INQ000477933]



4.367. These processes were documented in detail and work instructions were produced for new team members. The processes evolved over the relatively short period of intensive buying (3 months), and the process documentation[345] was updated accordingly[346]. The process was however consistent for all offers at a given time: all potential suppliers were asked to produce full product documentation, which was then checked before contract and price negotiation, and ultimately an award decision was made by the DHSC Accounting Officer. A 'compliance' role was created within the PPE Buy Cell[347]

4.368. The intensity and volume of the work carried out is shown by the below graphic which shows the number of offers at each stage of the PPE Buy Cell process as at 12 May 2020:

[345] GRW/352 - [INQ000477241]
[346] This process was described by the NAO as having '8 steps', which is a simplification.
[347] GRW/353 - [INQ000391410]



The Opportunities Teams

4.369. Initially, on 1 April 2020 there were 4 Opportunities Teams (deploying in total about 35 people). This increased to 12 Opportunities Teams by 19 May 2020.

4.370. Each Opportunities Team was tasked with speaking to potential vendors and checking the viability of their offers.

4.371. The "open source" approach, and the request for offers from business in the 10 April 2020 PPE Plan,[348] meant that a huge number of offers were received (c.25,000 offers from >15,000 suppliers). A large proportion of the offers were (while often well-intentioned) evidently not viable or suitable in that the items offered would not be clinically acceptable or that volumes would be trivially small.

4.372. There was significant political pressure (and the team members were well aware of the supply issues from the news) to review all the offers received because of a concern that a great offer (i.e. an offer of products which met the need and specification and were in stock) amongst the large number of unsuitable offers would otherwise be missed.

4.373. The PPE Buy Cell team had to find a way to triage the offers in order to distinguish good offers from unsuitable offers.

4.374. The unsuitable offers included those from vendors seemingly attempting fraud, from opportunists and from enthusiastic amateurs. As an example of the suspected

[348] GRW/307 - [INQ000050008]

fraudulent offers we received, there were numerous emails, received from persons all over the world, with an offer to buy 20m, 30m or 80m 3M 1860/N95 masks "sitting in a warehouse in Heathrow, ready for immediate purchase". After examining photographs of the packaging, 3M told the PPE Buy Cell that, if it ever existed, this equipment was either counterfeit or out of date. These offers, and variants of them which later emerged, still had to be subject to the initial review in case they were valid, even if they were later rejected. A common illusory, but less obviously fake, offer involved individuals saying they had connections in China and providing a spreadsheet containing thumbnail pictures of different PPE items and prices. Similar spreadsheets were readily available online. The individual who had made the offer would in all likelihood not really have a connection with a factory or manufacturer in China.

4.375. A direct approach to the key suppliers in the market – similar to the approach successfully adopted for the Ventilator Challenge – would have allowed a far more targeted and efficient approach to the procurement of PPE, and would have avoided the need for the HPL. The main difficulty in reviewing the offers received was the sheer volume of offers. This may have been compounded by:

4.375.1. The lack of sectoral experience or knowledge of medical products for most of the volunteers.

4.375.2. The lack of prior understanding, knowledge of or contact with the end-to-end supply chain. As explained above, many of the staff (such as the Cabinet Office officials) were new to this market. However, even SCCL and DHSC did not have a detailed knowledge of the end-to-end supply chain given the distributor-driven nature of the pre-existing market in the UK (see paragraph 4.271 above).

4.375.3. The absence of a centralised supplier list for the suppliers from whom NHS Trusts' had procured PPE directly pre-pandemic.

4.375.4. The lack of time to carry out a market analysis, such as the CTT staff would normally have conducted prior to carrying out a new project, although this was quickly undertaken by a CTT official (Rob Nixon) with the support of analysis commissioned by DIT colleagues.

4.376. The triage process set up to manage the volume of offers being received was that priority would be given to offers satisfying the following criteria:

4.376.1. **Criterion 1 (volume):** Offers for items of more than 250,000 units were treated as a priority. This was quickly increased to 1 million units. There was a smaller threshold for some items, such as 10,000 units for body bags.

4.376.2. **Criterion 2 (lead time**): Initially the priority was offers for PPE which was already held in stock by the vendors. Later the priority was for offers for PPE which could be provided within 2 weeks. Within 3 weeks of starting work, our perception was that almost all stocks worldwide had been exhausted, so the criterion changed to how quickly goods could be manufactured/provided.

4.376.3. **Criterion 3 (credibility)**: There were 3 elements to the assessment of credibility: (i) is the source of the product credible? (intermediaries were asked for the required product certification documentation), (ii) is the counterparty credible, i.e. does it have experience of exporting from China, relevant business relationships and good financial standing? and (iii) was there a fraud risk in the supply chain? Priority was given to more credible suppliers, such as existing NHS suppliers or those known to the NHS supply chain. When people claimed to be existing NHS suppliers this was checked. Caseworkers also assessed credibility when speaking to potential suppliers, particularly their ability to answer questions about the nature of the goods and how they met the specifications. This advice was communicated in the "Guidance on progressing offers" issued on 7 May 2020.[349]

4.376.4. **Criterion 4 (demand for products)**: every day there would be a focus on purchasing particular products depending on the changing needs and usage rates within the NHS. This prioritisation would be agreed at the 8.30am meeting and then passed on to the Opportunities Teams at the 9.30am meetings.

4.377. A team leader would allocate offers to individual Opportunities Team members reflecting the agreed daily priorities. Given the sheer number of offers, within the daily priorities and the offers assigned to them, the caseworkers (often more junior staff, at Senior Executive Officer grade and lower) had to make the decisions about which specific opportunities to pursue. A caseworker would be pursuing several

[349] GRW/354 - [INQ000477274]

offers in parallel to each other. Guidance was issued to Opportunities Caseworkers to help them sift offers.[350]

4.378. If the caseworker judged that the vendor and its offer was credible, then the vendor was asked to provide details of the products on offer, including specification, photos of the products and packaging (such as a photograph of the equipment with the CE marking showing), certificates of conformity, instructions for use, test results and factory certifications (e.g. ISO certifications of quality processes). The quality assurance documentation to be obtained by the Opportunities Teams was set out on 1 April 2020.[351]

4.379. These product details were necessary because it was impossible in almost all cases to visit the production facilities. Most goods were from China, though gloves were also produced in Malaysia, Thailand and Vietnam, some goods were produced in Taiwan and small amounts were produced elsewhere such as Turkey and Korea. Entry to China for non-Chinese nationals was strictly limited (only those with a diplomatic passport could enter China at that time), and internal travel within China was difficult (as many areas were 'locked down'). There were few UK government staff in-country with the necessary expertise to assess product quality or production facilities. It was therefore impossible, save on limited occasions, for anyone to conduct the factory visits that would normally be undertaken in usual circumstances before purchasing supplies from new suppliers.

4.380. Two established consultancies (Intertek and SGS) offered inspection services in China. Intertek and SGS were engaged by DHSC to carry out in-country inspections for a small number of contracts. However, it was not possible to engage them more widely because they were in high demand from other international buyers and had limited resources.

4.381. The significant reduction in passenger flights (which are normally used to transport goods in the hold) also meant it was not generally possible to obtain samples to inspect. It would have taken too long to receive samples via shipping. Only rarely did the PPE Buy Cell receive samples.

4.382. If an offer from a potential supplier was deemed viable by a caseworker following receipt of the further product details described above, the complete product

[350] GRW/355 - [INQ000496724]
[351] GRW/356 - [INQ000478791]

information package was passed to the Technical Assurance Team (see below) for verification. The package consisted of:

4.382.1. Product description (typically brochure).

4.382.2. Conformity documentation including details of CE marking.

4.382.3. Test Reports.

4.382.4. Pictures, including packaging.

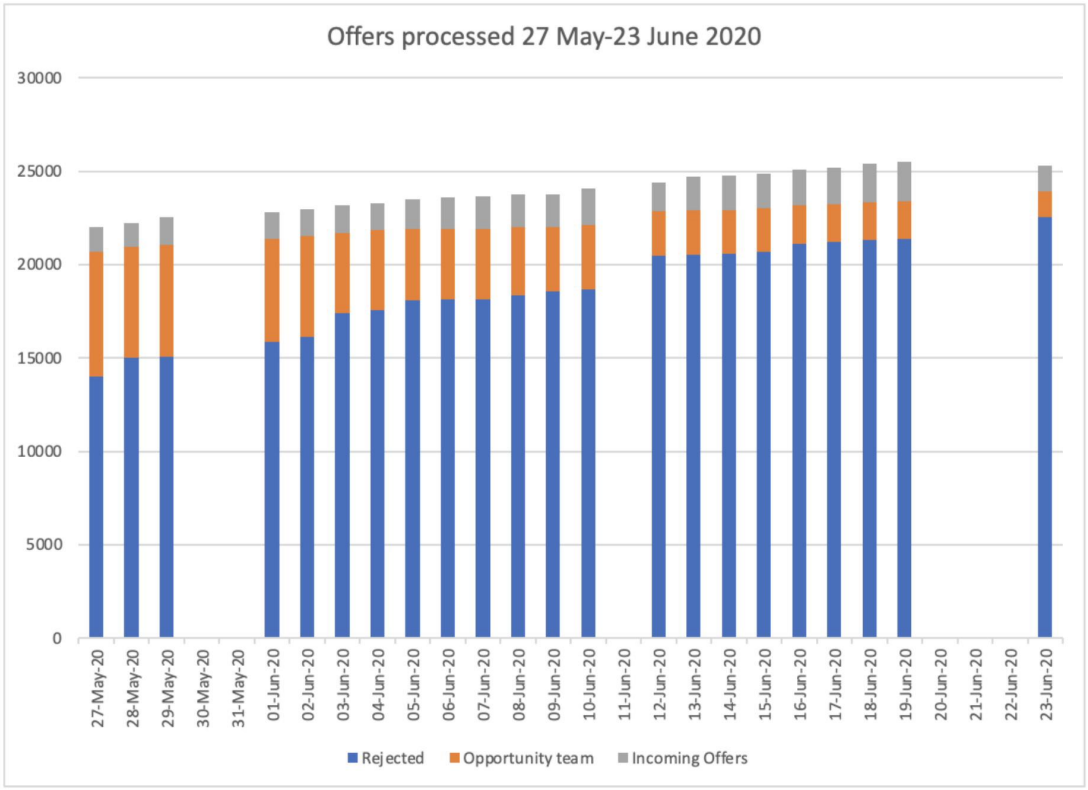
4.382.5. Instructions for use.

4.382.6. Details of quality certification held by the factory.

4.383. By 7 April 2020, the portal had received over 3,000 offers of support (2,946 offers from suppliers and 82 offers from manufacturers).[352] A backlog of offers for initial review, and then technical assurance review, grew because at peak 400-500 new offers were being received on the Portal every day.

4.384. The long backlog queue of offers that had arrived via the web portal needed to be reduced in order to avoid the risk of losing good offers before the product was sold to other countries. The Crown Commercial Service in the Cabinet Office engaged Arvato CRM Solutions to provide an outbound call centre service. Arvato was engaged by a call off from an existing CCS framework agreement. The role of this call centre was to make contact with and carry out an initial triage of all those who had submitted offers but had not yet been contacted. These were generally low volume opportunities. The call centre staff would validate the data submitted via the portal and identify any obviously irrelevant offers, such as offers for products which were not required. Many offers had expired, or the vendors could not be contacted on the telephone numbers entered into the portal. Where offers had not expired and vendors could be contacted, they were processed by the call centre and then submitted to the Opportunities Teams if potentially viable. The call centre was operational from 23 April 2020. Out of the c.3,000 offers processed by the call centre by 27 April 2020, c.1,700 were rejected or failed to respond to successive call backs. Once the backlog was cleared, the call centre was retained to provide the initial sift of the c.400 new offers received each day until 5 June 2020 when it finished its operations. A snapshot of how the offers were progressed week by week is shown below for 24 June 2020:[353]

[352] GRW/357 - [INQ000478813]
[353] GRW/358 - [INQ000477259], GRW/359 - [INQ000496761]



China Buy

4.385. A team of FCO and DIT staff on station in the Beijing Embassy was working, full-time, contacting potential sources of PPE (and other medical supplies, such as ventilators) in China from around 16 March 2020. This team identified a number of opportunities to buy large quantities of PPE directly from manufacturers or trading companies in China.

4.386. These opportunities were then passed to the UK-based part of the China Buy team in the PPE Buy Cell to prepare the offers for authorisation and contract.

4.387. 17 contracts were entered with Chinese producers and trading companies for PPE via the China Buy route.[354]

[354] GRW/360 - [INQ000477283]

4.388. On the information available to the Cabinet Office, the total value of the contracts placed and volume of PPE ordered via the China Buy team by 10 August 2020 was as follows (DHSC will have the final, complete data):[355]

Type of PPE	Total PO Value	PO Quantity
Apron	£96m	2,675m
Coverall	£2m	0.1m
Eye protection	£19m	10m
FFP2/3	£55m	38m
Glove	£310m	2,831m
Gown	£325m	67m
II/IIR	£71m	183m
Sanitiser	£20m	25m
Grand Total	**£897m**	**5,829m**

The High Priority Lane

4.389. As explained above, the standard route for making an offer of PPE was for potential suppliers to fill in the webform published on the gov.uk website (usually called 'the portal').

4.390. However, in March 2020 Ministers (or their private offices), MPs and senior officials referred offers of support directly to Health Ministers or to DHSC or NHS officials who were working to set up the Parallel Supply Chain.

[355] The DHSC Finance team issued a nightly spreadsheet of the purchases to-date [GRW/361 - [exhibit to follow]. This data has then been sorted and added to by the Cabinet Office to identify (a) the type of supplier (i.e. China Buy/ HPL), and (b) the category of PPE from the product description. The values are based on the daily conversion rate at the point of transaction, used to calculate the "Sum of GBP equivalent of amount ordered GBP" included in the finance team spreadsheet.

4.391. Often the suppliers who had made the offers would contact the Ministers or their MPs to check if their offers were being processed (sometimes on multiple occasions).

4.392. The MPs, Ministers or senior officials who had been contacted with offers of support and had passed the offer to the PPE Buy Cell were, unsurprisingly given the obvious pressures on the NHS, often keen to see that these offers were being followed-up and no key potential orders were being missed. As a result, and often following chasers from the suppliers, these referrers frequently contacted the leadership team of the PPE Buy Cell to check on the progress of the referred offers. Given the number of offers and referrals, handling these chasers was a significant drain on the PPE Buy Cell's time and resources and the repeated chasing risked duplication of offers.

4.393. As a result, a caseworker in the PPE Buy Cell was asked to field these requests on 22 March 2020. A small team of 4 was established in the PPE Buy Cell by 26 March 2020 to pursue these referred leads and provide feedback to those making the referrals.

4.394. On 1 April 2020, Max Cairnduff, a deputy director in the CTT in the Cabinet Office, was brought into the PPE Procurement Cell to lead and expand this team, which became known as the High Priority Lane ("HPL").

4.395. The HPL was a separate Opportunities Team dedicated to handling these referred opportunities that required greater stakeholder management. The HPL team was able to contact referrers proactively, meaning they were far less likely to request an update.

4.396. The principal purpose of the HPL team was to remove the disruption which these referrals were causing to the general open source system and the opportunities teams.

4.397. A dedicated mailbox for the HPL was established on 2 April 2020, so that everyone working on the HPL could see and access the referrals made, as opposed to different emails being sent to different individual caseworkers' email addresses. The mailbox was set up within a Cabinet Office email domain because it was easier to set up and access than a DHSC mailbox. Cabinet Office officials could not access a DHSC mailbox.

4.398. The existence of this dedicated mailbox was made known to the private offices of DHSC and Cabinet Office Ministers and senior officials in DHSC and the NHS, and subsequently more widely.

4.399. Offers coming into this mailbox were processed by the dedicated team. There was no policy or instruction for caseworkers on the HPL to contact suppliers more often or provide greater support to suppliers than in other Opportunities Teams.

4.400. Often the referrer (different to the source of the referral) would ostensibly be a Minister. However, this did not mean that the referral had been sent at the personal request of the Minister, as often an email is read in a Minister's private office and actioned as appropriate (for example by sending it to the dedicated mailbox) without on all occasions the Minister themselves being informed. In addition some MPs (and Ministers) passed on offers that they had received from their constituents.

4.401. On occasions, at times of peak demand the HPL paused its existing caseload in order to focus on items which were high priority, prioritising that type of PPE regardless of source. For example, on one weekend in mid-April 2020 the entire HPL paused its normal work to focus purely on gowns. There was a similar surge on Type II and IIR facemasks on 30 April 2020.

4.402. Save that the point of entry of the offers it was reviewing was different, and there was more internal reporting, the HPL operated in the same way as the other Opportunities Teams. It reviewed the viability of each vendor and its offer (i.e. the technical suitability) and sought further information by phone calls and emails.

4.403. The small offer pool/backlog and the dedicated resources meant the HPL team was generally able to review offers and progress them to Technical Assurance (if suitable) more quickly. The aim of the HPL was to make initial contact within 24 hours of a referral, as referrals from Ministers, NHS managers and senior officials were treated as priority tasks.

4.404. As with other Opportunities Teams, the HPL prioritised the review of the offers it received based on clinical demand and on the quality of the product and proposition generally.

4.405. The nature of the offers received by the HPL varied. There were broadly 6 different types of referrals:

4.405.1. Suppliers who had filled in the survey on the portal but had not been contacted by an Opportunities Team so had escalated their offer to ministers either directly or through their MPs.

4.405.2. Suppliers who were forwarded to the HPL from other points in the system as a means of escalation, despite no ministerial or similar involvement. This was exceptional and often where the offer had only a short time frame to close, or the supplier had filled in the survey on the portal but had not been contacted by an Opportunities Team so lodged a complaint.

4.405.3. Suppliers who had obtained a ministerial private office email address and directly contacted the minister's office with their offer. The private office then forwarded the offer to the HPL. It was generally not possible for the HPL team to know if the actual minister was aware of the offer.

4.405.4. Suppliers who had obtained the HPL mailbox address from somewhere and contacted it directly. Later on the HPL email address was known to be circulating in the public domain.

4.405.5. Suppliers who were personally recommended by ministers directly (rather than through their private offices).

4.405.6. Major corporate or intergovernmental offers or donations, often coming through from the FCO.

4.405.7. Some companies who approached SCCL with offers of PPE but which were not existing SCCL suppliers were referred by SCCL to the PPE Buy Cell. It is not clear why (potentially because caseworkers moved to the HPL were already processing these offers when they were transferred), but some of these offers were processed by the HPL team.

4.406. Some offers received by the HPL were diverted to the general "open source" portal, where appropriate. However, if it was identified on review that an offer perhaps should not have gone through the HPL, but it nevertheless was for a significant in-demand product it would still be processed by the HPL team to avoid a further handoff and hence delay.

4.407. Only the most worthwhile opportunities were pursued: opportunities looked at by any team, including the HPL team, which were not worthwhile were not taken further.

4.408. Where an opportunity received by the HPL appeared after information gathering to be worthwhile, it was passed to the Technical Assurance Team for validation, in the same way as by the other Opportunities Teams for offers made via the portal. Over time, there was a specific point of contact in the Technical Assurance Team who HPL caseworkers would refer offers to.

4.409. The Technical Assurance team and process, and all subsequent steps – the Closing Team, the due diligence, the Clearance Board and the Accounting Officer approval– were independent of the HPL team and their processes were carried out in the same way for HPL offers as for non-HPL offers.

4.410. As explained below, from April to June 2020 the Technical Assurance and Closing Teams were staffed and led primarily by MoD (DE&S) personnel. From May 2020 onwards these teams were supplemented by staff from the NHS and elsewhere in government. While the possibility of doing so was raised by the HPL team, no preference was given to offers initially processed by the HPL Team at the Technical Assurance, or any subsequent, stage. The only consideration was quality and urgency of need.

4.411. The HPL did not make any decisions to award contracts. The HPL only made decisions to progress offers which seemed worthwhile to the next step in the process, using the same criteria as other Opportunities teams (see paragraphs 4.369 onwards).

4.412. Different referrers behaved differently. Some referrers would pass an offer on and not follow up. Other referrers would regularly ask the HPL Team for updates. Updates would be provided such as “the item is not something we are interested in buying”.

4.413. The only ways that the HPL team was still involved in an offer once it had been sent to Technical Assurance were:

4.413.1. Providing updates to referrers. The caseworker would try to obtain an update from the relevant person outside of the HPL team and then provide it to the referrer. Opportunities were marked as “HPL” (or “VIP” as it was sometimes called) to make this process of seeking updates

work more efficiently and minimise the diversion caused by such update requests.

4.413.2. On rare occasions, when there was a real push (for demand reasons) to get an offer completed, assisting to prepare the Closing Pack of an offer which had originally come through the HPL and which had now passed through the subsequent (independently staffed) steps.

4.414. The handling and discussions with the referrers were, therefore, carried out by members of the HPL team, rather than those carrying out the Technical Assurance or Closing processes. This protected the Technical Assurance and Closing Teams, allowing them to focus their time on their primary tasks and also limiting the scope for conflicts of interest.

4.415. The HPL was not just used to process referrals from senior officials. Donations and a number of high-volume, credible offers also came via the HPL. This was for 3 reasons:

4.415.1. Some people, including many referrers, formed the view that the purpose of the HPL was to take forward particularly high value offers, and so forwarded those offers to the HPL.

4.415.2. Those making the referrals often had suitable commercial or business contacts for the sourcing of PPE. Most of the offers made on the HPL were from commercial intermediaries in contact with manufacturers in China.

4.415.3. As the HPL became better known, senior officials took to referring offers to the HPL which they considered were credible and worth investigating.

4.416. The HPL was closed on 24 June 2020, once the bulk of offers had been processed, with an out-of-office turned on for the designated mailbox.

4.417. Overall, approximately 450 companies and individuals made offers that were processed by the HPL, leading to the award of contracts to 52[356] currently identified suppliers (i.e. almost 90% of companies/individuals referred through this route were

[356] Work done in preparation for the Inquiry has identified an extra HPL company, Luxe Lifestyle Ltd.

unsuccessful).[357] Most suppliers who were awarded a contract did not have all of their offers or all of the product lines in these offers accepted.

4.418. A list of 50 suppliers who at that stage had been identified as having been awarded contracts via the HPL, along with the source of the referral and actual referrer for each supplier, was published on gov.uk in November 2021. An additional identified supplier was added in February 2022.[358] A further HPL company, Luxe Lifestyle was identified in May 2024 following a review of evidence in preparation for this Inquiry. This company was awarded a contract for gowns and FFP2 respirators worth £25.8m on 1 May 2020, and was referred to the HPL by an official working for JACT, the joint FCO/DIT task force. Out of these 52 suppliers awarded a contract, the actual referrer into the HPL for less than half was an MP, Minister or Member of the House of Lords.

4.419. A sub-team of the HPL was also tasked with dealing with significant donations of PPE from companies (which often came from referrers in any event), private individuals and other countries. These donors are not included in the 52 suppliers referred to above. About 800 donations were offered by companies, individuals or foreign governments.[359] Donations were still subject to review and validation by the Technical Assurance Team to decide if they were suitable for the NHS supply chain. Approximately 60m items were accepted with an estimated cost of £45m.[360] Some of the goods offered (in good faith) were not medical grade PPE or were not of a specification acceptable to the NHS (for example KN95 respirators and type II masks). Where possible these non-compliant donations were diverted to volunteer organisations (such as St John's Ambulance) for potential use outside the NHS.

4.420. On the information available to the Cabinet Office,[361] the total value of the contracts placed by DHSC, and the volume of PPE in those purchase orders, which were referred by the HPL were as follows:[362]

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[357] The use of spreadsheets to record the actions of the PPE Buy Cell before 16 April 2020 means that there may be some offers/contracts which went through the HPL but which have not been recorded or subsequently identified as having done so.
[358] GRW/360 - [INQ000477283]
[359] GRW/362 - [INQ000496917]
[360] GRW/363 - [INQ000477279]
[361] These totals differ from the NAO 2022 report. DHSC will have the final, complete figures.
[362] The DHSC Finance team issued a nightly spreadsheet of the purchases to-date. GRW/X - [exhibit to follow] This data has then been sorted by the Cabinet Office to identify (a) the type of supplier (i.e. China Buy/ HPL), and (b) the category of PPE from the product description.

Type of PPE	Total PO Value	PO Quantity
Apron	£55m	519m
Coverall	£342m	19m
Eye protection	£198m	98m
Eyewear	£303m	207m
FFP2/3	£570m	207m
Glove	£416m	2,484m
Gloves	£203m	1,325m
Gown	£727m	90m
II/IIR	£877m	2,644m
Other	£8m	5m
Sanitiser	£43m	10m
Unclear	£3m	3m
Grand Total	**£3,747m**	**7,610m**

4.421. I recognise that the High Court in Judicial Review proceedings brought against DHSC found that "the operation of the High Priority Lane was in breach of the obligation of equal treatment" because such offers received earlier consideration at the initial offer review stage, and the Court found that "speed in getting an offer to Technical Assurance improved the chances of securing a contract."[363] However, for the 2 HPL suppliers in respect of whom the challenge was made, the Court held that the challenge to the award of the contracts failed because it was very likely that their offers would have resulted in the award of contracts even if they had been made through the standard portal, rather than the HPL. The Judge stated that the 2 HPL

[363] GRW/14 - [INQ000477966]

suppliers' opportunities "justified priority treatment on its merits" and "[r]egardless whether they were made through the Portal and assessed by the Opportunities Team, or were assessed by the High Priority Lane Team, it is very likely that the offers would have resulted in the award of the [supplier's] contracts".

The Technical Assurance Team

4.422. If an offer was deemed suitable by the China Buy team or the Opportunities Teams (including the HPL team), the complete product information package was passed to the Technical Assurance Team for review and verification.

4.423. Cabinet Office officials were not members of the Technical Assurance Team.

4.424. Initially, the Technical Assurance Team was staffed by 1 or 2 SCCL employees from its "Clinical and Product Assurance" (CaPA) unit.

4.425. A Defence Quality Assurance Field Force Team (with 24 staff) from MoD (DE&S) was deployed in the first week of April 2020 to replace the CaPA staff as the Technical Assurance Team. This team later won an International Quality Award for its work during the pandemic. The team also had significant NHS, MHRA and PHE involvement, and a colleague from SCCL who was responsible for liaising with these bodies, for example to seek derogations. Training material was produced to instruct this team on the checks needed for PPE.[364]

4.426. The Technical Assurance Team checked:

4.426.1. That the product documentation was complete, (where possible) genuine, and relevant for the category of goods on offer.

4.426.2. If the origin of the goods was in China, that the producers had the necessary export permits.

4.426.3. For forged documentation. Generally these were fake certificates purporting to be from actual certifying bodies. There were also certificates from a body in Italy (ECM) that denied that it certified PPE at all. A number of suspect certificates were identified. According to the end of assignment report by DE&S, who led the Technical Assurance Team, between 6 April 2020 and 25 June 2020, the Technical INQ000478827Assurance Team identified 252 suspected counterfeit

[364] GRW/364 - [INQ000478827], GRW/365 - [INQ000496918]

offers.[365] Those offers/potential deals were stopped on the basis that the products were not supported by sufficient documentation. Generally no further action was taken because the priority was on purchasing PPE and it was difficult to know where in the supply chain (or geographically) the fraud had occurred (for example, the fraudulent certificate may have been produced by the factory, or by an entity in the middle of the chain, or by the direct counterparty of the PPE Buy Cell).

4.427. A step-by-step guide for the Technical Assurance Team was issued by DE&S on 2 April 2020.[366] There were subsequent revisions to and versions of this guide.[367]

4.428. If the Technical Assurance team wanted more information to complete checks on a product offer, it would ask the case manager in the Opportunities Team who would then request it from the supplier.

4.429. In the early weeks of April 2020, the Technical Assurance Team concentrated on validating large offers from China sourced via the Beijing Embassy and the China Team.

4.430. If the product information was deemed acceptable by the Technical Assurance Team, then the case was passed to the Closing Team.

Due diligence

4.431. Due diligence was undertaken on the immediate counterparty, and on the manufacturer in some cases. In practice, it was difficult to obtain detailed financial information about entities in China.

4.432. The FCO engaged a consultancy, "Company A" to carry out due diligence on companies domiciled outside the UK. In particular, counterparties identified by the China Buy team were examined by "Company A".

4.433. The Cabinet Office's Markets and Suppliers team also carried out due diligence, primarily on UK companies. During the pandemic the Cabinet Office Director in charge of this team was Coleen Andrews, and the team undertaking due diligence was led by Dan Gillett. The Cabinet Office used its pre-existing access to the following resources to carry out due diligence checks:

[365] GRW/363 - [INQ000477279]
[366] GRW/364 - [INQ000478827]
[367] GRW/366 - [INQ000477925] (version 1.4) GRW/367 - [INQ000477249 (version 2.0)

4.433.1. FAME[368], which provided UK supplier financial accounts information.

4.433.2. Company Watch, which provided a Company Health or (H) score, automatically generated using profitability, financial ratios and supplier information as an assessment of how likely the company was to fail over the next three years.

4.433.3. Credit Safe[369], which provided a credit rating from 0 to 100.

4.433.4. Porge[370], which provided wider public sector spend data.

4.433.5. Bravo, which is a database of central Government spend data.

4.433.6. Politically Exposed Person checks[371], using a tool provided by HMRC.

4.434. The Due Diligence unit embedded in the Market and Suppliers team, which comprised only 1 or 2 people, only had capacity to do around 20 due diligence checks a day. Most due diligence was conducted at the Closing stage of an offer.

4.435. As far as the Cabinet Office is aware all offers should have been subject to due diligence before any contract was awarded (with the nature/extent of the due diligence developing as time went on). However, currently the Cabinet Office has not been able to identify records showing that due diligence was carried out on some suppliers with whom contracts were entered in the first few weeks of the PPE Buy Cell. It may be that the due diligence was carried out but, given the urgency and lack of a centralised record keeping system at this stage, no records were kept.[372]

4.436. On 16 April 2020, the Markets and Suppliers team engaged Contingent, a specialist consultant, to carry out "Know Your Supplier" checks including company information – such as the latest accounts, date of incorporation, trading status and the directors – financial information and screening data. The cost of engaging Contingent was recharged to DHSC.

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[368] A database of company and director information provided by the Institute of Chartered Accountants in England and Wales (ICAEW).
[369] Creditsafe is a privately owned provider of on-line company credit scores and credit report information.
[370] Porge Research, now owned by Oxygen Finance.
[371] HMRC defines a Politically Exposed Person as "typically, a non UK or domestic member of parliament, head of state or government, or government minister and their family members and known close associates"
[372] This point was noted by the NAO in its Investigation into government procurement during the COVID-19 pandemic published on 26 November 2020.

4.437. From 4 May 2020, the Markets and Suppliers team engaged "Company B", another specialist consultant, on a pro bono basis to conduct due diligence on overseas companies, gradually replacing "Company A". "Company B" would complete due diligence checks for sanctions, company information, financial information, headline media and adverse media. All information collected by "Company B" was populated into an excel template.[373]

4.438. When Contingent or "Company B" did not have capacity, due diligence checks would be carried out by the Cost Assurance and Analysis Service (CAAS) in the MoD. A template CAAS due diligence report is exhibited.[374] Example CAAS and Markets and Suppliers Due Diligence reports are exhibited.[375]

4.439. The due diligence reports would produce a traffic light conclusion.[376] Potential suppliers would be marked Green (no concerns), Amber (proceed with caution) or Red (Major issues, significant assurances/mitigations necessary).

4.440. The sources of information used by the Markets and Suppliers team for due diligence increased from the start of May 2020 in particular as a result of the review by the GCFF. I address this review and the response to it in more detail in Section E below.

4.441. In terms of financial due diligence, I understood that the risk appetite of DHSC, as the contracting party, was different during this stage of the pandemic than it would have been in a normal situation. While the risks of spending money on a contract which was not performed were assessed, these were counterbalanced by the urgency of the pandemic and the need for PPE. The financial risks included the counterparty risk (e.g. the difficulty of making recoveries in the event of under- or non-performance), the risk inherent in making advance payments before taking title to goods, the risk that goods might be late or fail to be delivered in full quantity and the risk that prices might fall at some later period. If PPE was not available then there was a risk to the lives of those working in the NHS and in social care. All these risks had to be assessed using the judgement of the AO, taking into account the advice of those supporting him. My understanding is that, as a result, there was a greater than normal willingness to assume financial risk in purchasing PPE.

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[373] GRW/368 - GRW/X [INQ000477940]

[374] GRW/369 - [INQ000477951]: CAAS Report Template.

[375] GRW/370 - [INQ000497218], GRW/371 - [INQ000497219], GRW/372 - [INQ000497220], GRW/373 - [INQ000496725], GRW/374 - [INQ000496721], GRW/375 - [INQ000496726]

[376] GRW/376 - [INQ000477962], GRW/377 - [INQ000478801], GRW/378 - [INQ000480121], GRW/379 - [INQ000513003]

4.442. As part of the due diligence, the directors of potential suppliers were checked by the Markets and Suppliers team using an HMRC tool that flagged whether they were Politically Exposed Persons. The results of these checks (positive or negative) were recorded on the Due Diligence report forwarded to the Closing team. One element of the due diligence which the PPE Buy Cell carried out was to identify and scrutinise any modern slavery concerns. Suppliers of gloves from east Asia were a particular concern following press reports at the time.

4.443. A series of rapid due diligence checks, or pulse checks, on purely financial grounds were also conducted, starting in mid-May 2020, on yet-to-be processed offers to remove large volumes of less credible sources. These checks were primarily aimed at UK companies. The checks were performed using a tool called Duedil or by checking Companies House data. If it existed, the supplier's website was examined to give background. Results were generally recorded in the case record for that company in Mendix to inform the Closing Team and anyone else involved in processing the case of any concerns raised by the pulse checks. Instructions for the process, a sample Mendix record and a sample Duedil report are exhibited.[377] The pulse check was additional to, rather than a substitute for, full Due Diligence, which had to be carried out before a contract was let.

The Closing Team

4.444. Cabinet Office officials were not part of the Closing Team.

4.445. The Closing Team was initially staffed by commercial personnel from MoD DE&S. NHS staff were subsequently trained to supplement and ultimately replace the DE&S team.

4.446. The leaders of the Closing Team (Bruce Marshall and Mike Beard from the MoD) joined the PPE Buy cell at the very end of March 2020.

4.447. By late April 2020 approximately 45 staff had been deployed from DE&S to the Closing Team.

4.448. Lawyers from the Government Legal Department (and their co-sourcing partners TLT) worked with the Closing Team. In particular, contracts above a certain threshold value or with identified risks such as non-standard terms were subject to review by TLT. TLT had a portal that was used for Closing Team members to upload any non-standard terms that were being requested by suppliers.

[377] GRW/380 - [INQ000496755], GRW/381 - [INQ000496713], GRW/382 - [INQ000496765]

4.449. The job of the Closing Team was to take an offer of goods deemed acceptable by Technical Assurance through to a negotiated deal agreed with the vendor and a signable contract.

4.450. The Closing team negotiated price, payment terms, delivery and commercial terms with the vendor. Commercial terms for contracts other than with Chinese companies were usually based on a standard DHSC short form contract.[378] Instructions were issued on 23 March 2020 by Ed James, the DHSC Deputy Director in charge of procurement, that the DHSC's contract be used in preference to supplier contracts.[379] There was a separate contract for Chinese companies, which I understand was provided by the FCO/DIT team in the Beijing Embassy.

4.451. Offers were not simply accepted at the price offered. There were discussions and negotiations with suppliers to make sure that prices were agreed which reflected the value of that item of PPE in the market at the time.

4.452. As part of this negotiation, the prices offered were compared with other offers received by the PPE Buy Cell and with benchmarks provided by SCCL (from 8 April 2020) on both current offers from existing suppliers and pre-pandemic pricing.

4.453. After a few weeks, the PPE Buy Cell had data on the average price it had paid for a number of different kinds of product and established a Pricing Benchmark for each product family.[380] In this way we sought to ensure value for money at that moment in time, even though, due to the time constraints, formal competitions were not viable, and due to the supply and demand factors mentioned earlier, prices were multiples more than before (or after) the pandemic.

4.454. The guidance to the Closing Team was to seek to agree the best value for all contracts and not to agree a price which was 25% more than the Pricing Benchmark (i.e. the rolling average unit price for the last two weeks) for that product.[381]

4.455. Advance payments were required by vendors in many circumstances. Many vendors were intermediaries who had to make down payments to manufacturers to secure production slots. Some vendors asked for 50% of the total deal value on contract signature.

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[378] GRW/383 - [INQ000477956]
[379] GRW/384 - [INQ000496697]
[380] GRW/385 - [INQ000496719] - snapshot example from May, GRW/386 - [INQ000496734] - June
[381] GRW/387 - [INQ000477931] - slide 11.

4.456. If the supplier had not contracted with the DHSC before (as was the case for many PPE suppliers), the Closing Team (or occasionally the Opportunities Team) also asked the supplier to fill in a 'DHSC New Supplier form' which contained a declaration relating to possible conflicts of interest between the supplier and the Department.[382] If a conflict was identified (by this form or some other route) then it was up to the Closing Team, in conjunction with other colleagues, to put in place and record a suitable mitigation. The new supplier forms were passed to DHSC for action and archive.[383]

4.457. Once the terms of the contract were agreed and it was ready for signing, the Closing Team would prepare a 'Closing Pack', containing evidence of the due diligence, the new supplier form (if needed), details of technical assurance and a summary of the commercial terms, including a market price assessment.

4.458. The Closing Pack was sent to DHSC's finance team for final scrutiny, and only the Accounting Officer had the authority to give an offer final approval.

4.459. On 5 May 2020 a Clearance Board was established. From 6 May 2020 a 'deal form' summarising any contract for over £5m would be sent by the Closing Team to the Clearance Board in the PPE Buy Cell for its review and endorsement before the Closing Pack was sent to the DHSC's finance team for final approval by the Accounting Officer (see the following section).

4.460. The Closing Pack included:[384]

4.460.1. Proforma invoices from the supplier.

4.460.2. A contract signed by the supplier.

4.460.3. An order form.

4.460.4. A requisition request.

4.460.5. A funding approval request.

4.460.6. The DHSC 'New Supplier Form' (if needed).

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[382] GRW/388 - [INQ000496702]
[383] see End-to-end Closing Process Map GRW/389 - [INQ000496704]
[384] GRW/390 - [INQ000480603]; GRW/391 - [INQ000477242]; GRW/392 - [INQ000477932]; GRW/393 - [INQ000480123]; GRW/394 - [INQ000477303]; GRW/395 - [INQ000480109]; GRW/396 - [INQ000480116]; GRW/397 - [INQ000480122]; GRW/378 - [INQ000480121]; GRW/379 - [INQ000513003]; GRW/398 - [INQ000480120]; GRW/399 - [INQ000480118]; GRW/400 - [INQ000480124]; GRW/410 - [INQ000477244]; GRW/402 - [INQ000480111]; GRW/403 - [INQ000480117]; GRW/404 - [INQ000496701] [Example closing pack]

Clearance Board

4.461. Over the early May Bank Holiday 2020, DHSC's banks challenged some of the payments that DHSC had made for PPE, flagging that some of the counterparties represented a risk. One of the counterparties in question was Ayanda, and measures were taken to ensure that prepayments went directly to the producing factory (as requested by Ayanda). The goods from this transaction were delivered in full as described in paragraph 4.496 below. Data regarding other transactions and counterparties is held by DHSC.In order to reassure the banks and to bring greater rigour to the buying process, the PPE Buy Cell established a 'Clearance Board'.

4.462. The Clearance Board was chaired by Chris Hall, the Deputy Chief Commercial Officer in the Cabinet Office, and standing members included Melinda Johnson (DHSC Commercial Director and the alternate chair), Jennifer Nichols (Deputy Director of Finance at DHSC with responsibility for PPE payments), and Ed James (Deputy Commercial Director at DHSC and head of the procurement team). The Clearance Board met most weekday evenings at 6pm, and on occasion at the weekends.

4.463. The Clearance Board reviewed, and had to endorse, every deal over £5m, as a prior step before the final decision to place a contract was made by DHSC. The deals were presented by a Senior Civil Servant from the PPE Buy Cell (normally but not exclusively from the Closing Team) using a completed "Request for deal approval" form.[385] The minutes of this board are exhibited up to 30 June 2020.[386] Minutes after this date are held by DHSC as Melinda Johnson took over as chair from 1 July 2020.[387]

4.464. The Clearance Board would ask questions about the supplier and deal, such as the nature and pricing of the goods, the provenance of the goods, the strength of the counterparty and what due diligence had been completed.

4.465. Deals which were endorsed by the Clearance Board were passed to DHSC colleagues in the Commercial and Finance teams, who then passed the deal to the Accounting Officer for final approval. Many deals were not endorsed by the Clearance Board, and the submitters were asked either to renegotiate with the potential vendor, perform additional due diligence (such as in relation to modern

[385] GRW/405 - [INQ000480115]
[386] GRW/406 - **[INQ000522285]**
[387] GRW/407 - [INQ000497263]

slavery concerns) or get further assurances. Some deals were rejected as unsuitable.

4.466. On average, 7 deals were reviewed every time the Clearance Board met.

4.467. A running set of daily minutes for the Clearance Board was maintained, recording the supplier, the value of each contract, the decision (A = approved, R = refused, FI = further information) and the minutes and actions.

4.468. Issues of concern with a particular deal were raised to the Clearance Board. On two occasions the Clearance Board was asked to opine on conflicts of interest (or perceived conflicts). On the first occasion the Board asked the Opportunities Team to go back to the supplier and obtain further assurances, which it did. On the second occasion a solution was put forward by the supplier (an 'ethical wall' between two teams) which was endorsed by the Clearance Board. The deals were then passed to the Accounting Officer as described above in 4.459. These actions are recorded in the Clearance Board minutes.[388]

The Rapid Response Team

4.469. The (deliberately) sequential and independent organisation of the PPE Buy Cell was designed to ensure each order had to be reviewed by separate people, but that did mean there were multiple handoffs and work queues started to build up at each step of the procurement process. It was possible for deals to take anywhere between 10 and 30 days to complete from the first time that a caseworker in the Opportunities Team looked at them. Handling time was not the issue; some deals required several passes through Technical Assurance as product information was incomplete, other deals bundled multiple products, some products required waivers from regulators and queues built up for processing by Technical Assurance and Closing teams.

4.470. On 24 April 2020, the first Rapid Response Team was set up within the PPE Buy Cell. Each Rapid Response Team was staffed by taking 1 person from each of the specialist teams in the PPE Buy Cell, and assigning a dedicated project manager to each team.

4.471. As a result, each Rapid Response Team was a single, multiskilled virtual team assigned to one deal. The aim was to reduce handoffs and delays.

[388] GRW/406 - **[INQ000522285]**

4.472. A Rapid Response team would take a candidate case – sometimes from the general Opportunities stream and sometimes from the HPL. The candidate cases would be cases which were expected to be simple to complete, but which offered worthwhile quantities of priority goods.

4.473. The idea of the Rapid Response Team was to be able to process cases more quickly. In contrast to the standard timetable of 10 to 30 days, the aim of the Rapid Response Team was to process a case (from start to finish) in 1 day or 2 days maximum. Its first case was closed in 10 hours.

4.474. A key way in which the Rapid Response Team sought to achieve this faster processing time was a 'fail fast' mandate. If the Rapid Response Team considered that a deal was likely to take longer to process than 1 or 2 days, for example because of assurance or due diligence issues, it would stop working on the case and return it to the normal process.

4.475. The number of cases taken on by the Rapid Response Teams was dictated by their capacity. At the peak of buying activity in late May 2020, 4 Rapid Response Teams were running in parallel. The operations of the Rapid Response Teams were tracked in an excel spreadsheet.[389] In total 96 cases went through Rapid Response Teams leading to 21 contracts.

Final approval

4.476. DHSC's finance team, which was outside the PPE Buy Cell and supported the DHSC Accounting Officer, would review the Closing Pack and prepare a submission for their Accounting Officer's approval. This review was undertaken for all PPE contracts entered through the Parallel Supply Chain regardless of buying route, including China Buy, new UK Buy including the HPL and UK Make.

4.477. As explained above, the Accounting Officer for PPE expenditure in DHSC was David Williams, the Second Permanent Secretary at DHSC. Approval for contracts below £100m was delegated to David Williams' Finance Directors, Chris Young (the Finance Director of DHSC) and Jon Fundrey (who was the Chief Operating Officer of the MHRA, and seconded to DHSC to act as an extra Finance Director focused full time on PPE). To the best of my knowledge, all PPE contracts processed by the PPE Buy Cell or PPE Make went through this process of AO approval and there were no exemptions.

[389] GRW/408 - [INQ000513019]

Controls

4.478. Before the pandemic, most PPE contracts were entered into by NHS Trusts or were the subject of call-offs from a SCCL framework, and were thus not subject to Cabinet Office controls. A contract entered into by DHSC over £10m would be subject to the controls. As stated at paragraph 1.47, on 22 April 2020 DHSC requested that all PPE purchases would be exempt from the Cabinet Office controls. Given the critical need to procure at speed, advance approval of PPE spend over £10m was suspended under the conditions that HM Treasury had set when releasing the PPE budget to DHSC.[390] This exemption applied to all purchasing routes including SCCL, PPE Make, China Buy and New Buy (including the HPL). Retrospective approval of this approach was confirmed by Lord Agnew in May 2020.[391]

4.479. Payments made by the PPE Buy Cell had to be approved by the Chief Secretary to the Treasury (CST). The spend on contracts entered prior to 25 March 2020 were approved by a series of standalone payment requests by DHSC on 22, 23 and 25 March 2020.[392] On 25 March 2020, CST granted a delegated funding envelope to DHSC for PPE.[393] This delegated funding envelope was periodically increased.

4.480. The funding envelope granted by CST to DHSC was subject to conditions summarised in the letter from the CST to Secretary of State for Health and Social Care and the Chancellor of the Duchy of Lancaster and Minister of State for the Cabinet Office on 24 April 2020.[394]

IT and Data Management

4.481. The IT systems used by SCCL and DHSC in March 2020 could not support the influx of staff in the PPE Buy Cell. The Cabinet Office did not have an IT system ready which could handle the volume of users or transactions.

4.482. In late March 2020, the PPE Buy Cell therefore started entering the information about contacts and opportunities in spreadsheets. Initially, incoming offers from business and the public were processed through a Survey Monkey site created by Deloitte on or before 23 March 2020. On 30 March 2020 such offers were directed

[390] See paragraph 1.45 for correspondence
[391] GRW/21 - [INQ000496906]
[392] GRW/206 - [INQ000480114]
[393] GRW/206 - [INQ000480114]
[394] GRW/207 - [INQ000512995]

to a custom webform which produced a spreadsheet of opportunities for the caseworkers in the Opportunities Teams to review.

4.483. As the PPE Procurement Cell grew in size, it was clear there were problems in maintaining data integrity and control with these spreadsheets.

4.484. Over the weekend of 4 and 5 April 2020 a Cabinet Office Data and Insights team (not part of the PPE Buy Cell) constructed a simple database application to contain details of offers and potential vendors using a low-code development platform called Mendix.

4.485. This database was referred to inside the PPE Buy Cell as Mendix and was rolled out successively to the PPE Buy Cell teams over 2 weeks from 14 April 2020.[395]

4.486. The Mendix database was a significant improvement on the spreadsheets. The forms filled out by suppliers on the portal were automatically fed into Mendix. It enabled some simple workflow management. Case documents could be uploaded to the Mendix database to be passed from the Opportunities Teams to the Technical Assurance Team and then to the Closing Team.

4.487. While an improvement, the Mendix database had its limitations. There was no link to DHSC's accounting software. The workflow arrangements were rudimentary. Overall, the data quality for individual cases depended on the diligence and the time taken to input the details by individual case workers.

4.488. As part of the transition to a "steady state" buying organisation, it was decided to transfer data from Mendix to Atamis, a Salesforce-based procurement system already being built for DHSC. Mendix data was ported to Atamis during July 2020 (after the peak buying period had passed). I exhibit example screenshots of the Atamis system.[396]

4.489. A lesson learned from the pandemic is that it would be prudent to have a suitable IT system sitting ready to use in such emergency situations. This system would include "Customer Relationship Management" (CRM) functions capable of receiving and recording thousands of phone calls and emails, with tracking set up to record the dates and times of supplier interactions, preset fields allowing tracking of the procurement stages and ultimate contract publication. It would also record any conflicts of interest and subsequent mitigations, and against which specifications the

[395] GRW/409 - [INQ000478815] - Standup meeting notes 11 April 2020, 9.30 meeting.
[396] GRW/410 - [INQ000477254]

offer was considered. Completed transactions would be fed automatically into the host department's procurement and payment systems.

Outcome

4.490. Overall, on the information available to the Cabinet Office, the total value of the contracts placed by DHSC from all routes/streams via the PPE Buy Cell (not including the PPE Make Cell or SCCL purchases), and the volume of PPE under those purchase orders, was as follows:[397]

Type of PPE	Total PO Value	PO Quantity
Apron	£206m	4,003m
Coverall	£564m	38m
Eye protection	£310m	159m
Eyewear	£519m	339m
FFP2/3	£902m	312m
Glove	£1,074m	8,036m
Gown	£1,674m	206m
II/IIR	£1,738m	4,978m
Other	£11m	10m
Sanitiser	£187m	62m
Unclear	£23m	9m
Grand Total	**£7,207m**	**18,206m**

[397] GRW/361 - [exhibit to follow] - This data is from the 10 August 2020 version of the nightly spreadsheet of the purchases to-date issued by the DHSC Finance team

4.491. The data on the value and quantity of the PPE actually delivered will be held by DHSC.

4.492. It was necessary to process a very large volume of offers in order to place these orders. A Power BI[398] analysis of the data available to the Cabinet Office[399] for why offers were not acceptable is shown in the graph below. The two funnel charts present rejection reasons for offers (which may be of multiple products) for both the HPL and non-HPL channels.

4.492.1. Overall, according to this analysis, only around 1.4% of non-HPL offers led to orders being placed, as opposed to 6% of HPL offers.

4.492.2. However, as can be seen from the analysis, more of the non-HPL offers were rejected earlier in the scrutiny process than the HPL offers. This might be because potential suppliers failed to complete the webform, filled it in incorrectly, did not respond to three attempts at contact or offered goods that the PPE Buy Cell was not tasked to purchase.

4.492.3. When comparing the "failure rates" of HPL and non-HPL offers it is important to note that the HPL had far fewer offers which were obviously unsuitable or unviable. HPL cases had a proactive contact, who had emailed a Minister or senior official. Non-HPL cases filled in a webform, and the contact details could well be incorrect. Almost all of the HPL cases offered PPE, whereas the general webform invited ‘support from business’ under many headings (including hotel accommodation), not just PPE. The general webform is exhibited[400]

4.492.4. There was little difference in the fall-out rate at the Technical Assurance (TA) stage (which was entered after it was determined that the offer had sufficient volume to be worth considering). For non-HPL offers, the 9% which had 'Tech Spec OK' represented 43% of the offers presented for TA, while for HPL offers the 16% accepted by TA represented only 38% of the offers presented. A larger proportion of non-HPL than HPL offers failed Due Diligence checks (84% of those checked as opposed to 63%).

[398] A Microsoft data visualisation tool
[399] GRW/411 - [INQ000496748], Mendix extract taken on or before 10 Dec 2020
[400] GRW/412 - [INQ000496904]

4.493. The Government has since the pandemic written off a significant value of the PPE purchased. This primarily reflects the very different market value of PPE post-pandemic rather than any concern about received quality falling short of required standards. The valuation of stock is carried out on a 'lower of cost and net realisable value' basis,[401] where the net realisable value is the expected sale price of the stock less estimated further costs to be incurred to get stock in a condition to be sold. The PPE acquired during the pandemic was largely purchased at the market value at the time. However, those market values were, given the demand, very high relative to the pre- and post-pandemic periods. Post-pandemic, the demand has significantly dropped meaning the market value of PPE has dropped too. As a result, the net realisable value of the PPE stock held is significantly less (at current market values) than the amounts for which it was purchased, i.e. the cost. The stock is valued on this lower basis, resulting in a write off. Some press reporting has erroneously reported the write-down adjustments (amounting to £9.9 billion)[402] as being down to 'duff stock'. This reduction in valuation is not generally a

[401] GRW/413 - [INQ000471050]
[402] GRW/414 - [INQ000496744] - DHSC annual report and accounts.

reflection of or caused by the quality of the stock, but due to this lower carrying value.[403]

4.494. By the end of June 2020, the data showed that the PPE procured from March 2020 to June 2020 would meet or exceed the volume targets set by DHSC. This was for the following reasons:

4.494.1. First, demand was lower than expected, especially outside the acute settings. The SAGE RWCS projections on which the projected demand and buy targets were set had not materialised and clinical and non-clinical interventions had proved effective.

4.494.2. Second, "shrinkage" was lower than anticipated. Almost all ordered stock, by that point, was either delivered or forecast to be so. DHSC will have the final data on the shortfalls in delivery or quality of the PPE ordered.

4.494.3. Third, some NHS organisations and social care providers had continued to procure their own PPE directly (so called "leakage") which reduced demand for centrally purchased items.

4.494.4. Fourth, at the volumes of PPE which were being procured (to meet demand), suppliers often stated that if it was to produce that volume it needed a contract for say 6 months to cover its costs because, for example, an expensive new machine was needed to produce so many items. This particularly impacted 'Make' orders which were on newly-commissioned manufacturing capacity.

4.494.5. Fifth, the relative surplus of some categories of PPE, such as aprons and some face coverings, partly reflected the success of the "Make" operation in significantly ramping up production of those items in the UK.

4.494.6. Finally, the volume of PPE required also ended up being less than predicted because of the development and introduction of vaccines far sooner than was predicted, and certainly faster than allowed for in any (RWCS) demand/target modelling.

[403] The exact details and data relating to write-down costs for PPE is held by DHSC.

4.495. In terms of shrinkage, the Cabinet Office is aware of instances where the combination of gaps or ambiguities in the detailed specifications[404], the number of new purchasers with limited experience of NHS procurement, and/or the pressures in trying to secure PPE, led to the procurement of items which were not suitable for the NHS. For example:

4.495.1. Millions of aprons were purchased which met the specifications but were in flatpacks. Many NHS trusts use aprons dispensed from rolls on the wall. As a result, many of the flatpack aprons have not been used by the NHS.

4.495.2. The preferred NHS standard for respirator masks is FFP3,[405] which specifies a 98% filtration efficiency at 0.6 microns. Almost all the rest of the world including much of continental Europe and the US uses a respirator with 95% filtration efficiency, coded FFP2 (in Europe), N95 (US) or KN95 (China). Production volume for FFP3 masks is much lower than for FFP2, which are made on the same machinery. The PPE Buy Cell was instructed to buy FFP2 respirators against the event that FFP3 respirators were unobtainable. In the event sufficient FFP3 respirators were bought and the need for FFP2 respirators was much lower.

4.496. As discussed in the Judicial Review by the Good Law Project, in April 2020, some respirators were purchased from Ayanda that had earloops rather than behind-head straps, as described in paragraph 1.27 in the Executive Summary. The specification (issued 6 April 2020) valid at the time that Technical Assurance was conducted said that FFP2 and FFP3 respirators must conform to BS EN 149:2001+A1:2009. This specification also said that FFP2 respirators should have behind head straps (rather than earloops), although it was not clear if this was an explanation of the relevant standard or an additional requirement. A procurement of Ayanda FFP2 respirators went ahead on the condition that the respirators passed the BSI's own test of conformance with this BS standard including a 'fit' test. This test was duly passed on 24 April 2020. An information paper issued by HSE on 25 May 2020 said respirators with earloops might pass a 'fit' test, but the method used did not give an assurance that such a respirator would fit all the target population.[406] This was reflected in an update to the technical specifications on 28 August 2020 that said

[404] Note that Cabinet Office did not have a role in setting PPE specifications
[405] FFP - Filtering Face Piece
[406] GRW/415 - [INQ000477943]

"Due to concerns about adequacy of face fit and comfort, the head harness as specified in 7.13 (BS EN 149:2001+A1:2009) must not be of a design that holds the mask in place by the ears alone (aka ear loop)." On arrival at the distribution centre the masks were quarantined rather than released for NHS usage.

4.497. As set out in the Executive Summary at paragraph 1.26, such mistakes were in the context of a highly pressured process where procurement decisions had to be taken at extreme speed by staff who did not themselves have lengthy experience in healthcare procurement. However, there was never a policy or approach, of which the Cabinet Office was aware, to deliberately buy too much PPE. David Moore, DE&S, then head of the Technical Assurance team, later recommended that an experienced specification engineer be embedded with the assurance team in similar situations in future.

4.498. During the period of peak PPE buying, between late March and late June 2020, the country was still in lockdown. Having adequate stocks of PPE was one of the 5 tests set by the Government for coming out of lockdown. The clear direction from DHSC was that it wanted to have 4 months' worth of stock for each type of PPE in the country and available for distribution by November 2020. It was not the Cabinet Office's role to advise on how much stock DHSC required or should obtain. DHSC decided how much stock it wanted, with its focus on the second wave which was anticipated in or around winter 2020, but did not know exactly when or how bad it would be.

4.499. As the PPE Buy Cell reached the 4 month stock figure for different products in May/June 2020 it started to slow down buying. Overall, the buying operations ceased by the end of July 2020 (save for a couple of contracts, e.g. for new UK production capacity).

4.500. From June 2020, the role of the PPE Buy Cell had changed accordingly:

4.500.1. A team of contract managers had been established from May 2020 whose role was to liaise with suppliers, process any variations and monitor contract compliance.

4.500.2. From the end of May/early June 2020, the PPE Buy Cell was reorganised into teams for each specific category of PPE. The role of the category teams was to confirm that the flow of goods was sufficient to meet the now-forecast need. To manage the flow of goods some

contracts were renegotiated; some for early termination, and others for delayed delivery to reduce the large stockpiles building in the UK.

4.500.3. There were still a few contracts entered into after June 2020, including some for FFP3 respirators.

Contract Notices

4.501. From June 2020 onwards, CANs were published by DHSC on the Find a Tender Service and CFNs were published on the Contracts Finder Service for the contracts which had been entered into.[407] This process was managed by DHSC and was not part of the PPE Buy Cell's role. See Section C for more detail.

4.502. Where Regulation 32(2)(c) was used, for each contract a written justification for the use of Regulation 32(2)(c) was published as an Annex to the notices (see Annex D1 in the example).

Delivery and distribution of PPE

4.503. This section explains the process for the delivery and distribution of PPE. However, it is important to note that the PPE Buy Cell's responsibility (until June 2020) was limited to the production of the signable contract. No Cabinet Office officials were involved in any steps after the signature of the contract, except for the assistance the PPE Buy Cell provided in setting up contract management and inputting shipment information on the Uniserve "OneWorld" system (explained below).

4.504. The delivery and distribution of PPE was managed by the MoD on behalf of DHSC.

4.505. Once a contract for the supply of PPE was signed, any initial payment was made to the supplier and typically production was commissioned in the country of manufacture. Some contracts included shipping, in which case goods were received at a dedicated distribution centre in Daventry.

4.506. For other contracts, goods were received in the country of manufacture and had to be shipped to Daventry. Even in those cases, there was insufficient time (or resources) to carry out more than preliminary checks (e.g. counting the boxes and checking the labelling) before payments were made.

4.507. Initially, orders were placed with a wide range of different shipping arrangements. This made it difficult to review the data on what was ordered and what was arriving

[407] See for example: GRW/383 - [INQ000477956]

when (as this information was often held in spreadsheets). The goods being shipped by Uniserve, DHSC's shipping agent, were being tracked on Uniserve's "One World" system. Other shipping agents held data on their own systems, and DHSC did not have access to consolidated data.

4.508. Therefore, the PPE Buy Cell recommended to DHSC that it should retain Uniserve to produce a consolidated view of shipping data on its OneWorld system for all shipments for the PPE Buy Cell from 20 April 2020. Uniserve were already managing many of the shipments, and data from other shippers was added to this to give the PPE Buy Cell the first complete picture of what was coming into stock when.

4.509. Once the stocks in the UK of a particular product had reached a sufficient level, the inbound logistics switched from air to sea and rail, which were cheaper.

4.510. As explained above, inspection was difficult 'in country', therefore almost all goods were inspected on arrival in Daventry and before being allowed into the NHS or social care supply chain. DHSC was responsible for receiving, inspecting and storing the PPE.

4.511. Distributions were initially made from Daventry using a 'push' model. DHSC identified how much PPE was needed by the recipient and sent out regular deliveries of a predetermined mix of product types using a distribution partner, Clipper Logistics. These deliveries were made to hospitals, other NHS facilities and care homes. DHSC was responsible for the distribution of PPE, which was managed on its behalf by the army (MoD).

4.512. The entirety of this 'Parallel Supply Chain' process from pursuing an option to delivery to locations was set up from scratch in late March 2020. Ultimately approximately 58,000 additional health and care locations were receiving PPE from the PPE Buy Cell operations.[408]

Long term planning and transition

4.513. It was anticipated that the centralised buying of PPE would continue into 2021, as the need for PPE would continue with subsequent waves of COVID-19.[409] The PPE Buy Cell therefore put plans in place for this "steady state".

[408] GRW/416 - [INQ000477293]
[409] GRW/417 - [INQ000478803]

4.514. A Long Term Strategy planning group, led by Jonathan Marron, first met on 28 April 2020 and had 6 meetings in May 2020. This planning was done in conjunction with staff from NHS E&I who would likely take over responsibility for PPE buying.

4.515. External consultants (4C) were hired by DHSC following an informal competition (Accenture and Efficio were also asked to bid) to help with the design of the "steady state" organisation and the transition, including filling some interim management roles. The majority of the management positions were filled by executives brought in by Lord Deighton. From the end of June 2020, most of the CTT/CO officials were withdrawn.

4.516. The organisation of the future 'steady state' unit was intended to be category-based (with teams for gloves, masks, gowns, face coverings etc.), rather than the functionally-based organisation of the PPE Procurement Cell with different teams for opportunities, technical assurance and closing etc. These multi-skilled category teams were gradually introduced into the PPE Buy Cell from early June 2020 onwards, following a similar model to the Rapid Response Team. Their role was to understand the stock and demand situation for a particular related group of products, and match demand with incoming flows of those products. The methodology used was "Sales and Operations Planning".

4.517. The "open source" portal was closed on 2 July 2020.

4.518. The Cabinet Office involvement in the PPE Buy Cell ended at the end of July 2020.

4.519. A resolution team in DHSC was set up to close down orders no longer needed and resolve orders which did not arrive or did not meet the quality requirements. This resolution team is still active. The Cabinet Office is not involved in this team.

5. SECTION E: FRAUD

5.1. In this section I briefly outline work that was done to counter fraud prior to the establishment of the Government Counter Fraud Function (the 'GCFF') in October 2018. I then outline some of the counter fraud activity undertaken by the GCFF between October 2018 and the onset of the COVID-19 pandemic. I then address some of the work done by the GCFF during the pandemic to mitigate public sector fraud specifically in relation to procurement.

5.2. The Cabinet Office has procedures in place that reduce the likelihood of fraud, for example the Civil Service Code, disclosure of conflict of interest and procurement processes. It is the responsibility of budget holders, with delegated authority from the Accounting Officer, to understand and manage fraud risk within their areas of responsibility. In practice this means budget holders are accountable for: assessing the types of fraud risk in their areas in liaison with the Cabinet Office Counter Fraud Team if need be; taking steps to prevent and detect fraud; and ensuring adequate countermeasures are reviewed and new countermeasures implemented to help reduce the risk of fraud. The Cabinet Office Counter Fraud team supports the Cabinet Office in understanding and acting on fraud risk in its areas of work. The Cabinet Office Counter Fraud Team is not the same as the Centre of the Counter Fraud Function which is also based in the Cabinet Office (referred to as the Centre of Expertise (CoEx) in the Government Counter Fraud Function (GCFF) and which in turn became the Public Sector Fraud Authority (PSFA) in August 2022.

5.3. During the pandemic response, in relation to PPE, tests and ventilators, the processes relating to fraud prevention were enacted by the delivery teams (in DHSC and CO).

5.4. I have described below some of the general work on fraud prevention which was carried out during the pandemic, where I consider it necessary to show the range of activities being performed within the Cabinet Office, focusing on the work undertaken by the Centre of the Function (now PSFA) in the Cabinet Office rather than the CO Fraud Team. This is in the expectation that the Inquiry will be assisted by understanding that broader work. It should however be noted that many issues or recommendations that I discuss below arose in the context of areas unrelated to procurement of the items which this module is principally focused on (ventilators, PPE and testing). In particular, many related to the claiming of furlough or business support payments.

Period prior to the GCFF

5.5. In 2010 the Efficiency Reform Group was established, tasked to consider how to reduce spending across government and support UK growth. The Fraud Taskforce was also established in 2010 to provide a forum where Ministers, experts and officials could provide strategic guidance and oversight of cross government initiatives, jointly monitor progress of initiatives, and support the development and delivery of programmes by working together to solve problems or resolve escalated issues. This later evolved into the Fraud, Error and Debt Taskforce and finally into the Fraud, Error, Debt and Grants Taskforce.

5.6. In 2011, the Fraud, Error & Debt (FED) team was established in the Cabinet Office as a policy team at the centre of Government to better understand what government was doing and to ensure progress and agree cross system activity to take more action on fraud, error, debt, and later, in grant making. Part of this team subsequently became the PSFA in August 2022.

5.7. Data on tax and welfare showed that more could be done to reduce losses from fraud and error thereby reducing public spending (or increasing income through tax). In 2013 research undertaken by the policy team working under the FED Taskforce identified that the evidence base for the level of fraud was limited, but the evidence from comparators indicated that there was likely to be significant levels of unknown and undetected fraud and error across other departments (outside welfare and tax) which could be found and reduced.

5.8. In 2016, the NAO published a review of the public sector fraud landscape.[410] This review noted that the Cabinet Office had provided valuable central guidance and expertise to departments to improve the way they manage fraud, it observed that there were deficiencies including:

5.8.1. That the exact scale of fraud within Government was unknown and that there was a large disparity between what fraud and error was reported and what other available estimates suggest might have been occurring;

5.8.2. That Government lacked a clear understanding of the scale of the fraud problem and departments varied in their ability to identify and address fraud risks;

[410] GRW/418 - [INQ000477231]

5.8.3. That it was difficult to assess if Government action was improving fraud detection or prevention because of the lack of data and absence of measures to evaluate performance; and

5.8.4. That Departments' capacity and capability to manage fraud was mixed.

5.9. Other deficiencies which existed prior to 2016 included:

5.9.1. Limited pockets of investment focused in tax and welfare leading to mixed capability in other areas;

5.9.2. No formal professional structure, training or agreed standards for an increasingly complex area;

5.9.3. A limited understanding of the levels of fraud and error outside tax and welfare;

5.9.4. No agreed outcomes or definition of what effective counter fraud management was; and

5.9.5. Lack of transparency with little or no publication around losses or fraud management.

5.10. It was in this context, as well as a wider context of fraud management issues within large organisations generally, that the GCFF was established.

The Government Counter Fraud Function

5.11. The GCFF, which was established in October 2018 alongside the Government Counter Fraud Profession (the 'GCFP'), is one of the Government's functions.[411] At the time of the pandemic it was led by a small team of circa 40 people in the Cabinet Office who acted as a central team and Centre of Expertise for the over circa 16,000 public servants who work to find and fight fraud across the public sector - including those working to understand and mitigate the fraud risks within their organisations and those who work in the public sector to fight wider economic crime.

5.12. The GCFF was set up to take more action on fraud across government, and to use the functional model to drive activity and build expertise in countering fraud. This functional model was adopted to enable cross system activity.

[411] GRW/419 - [INQ000471038]

5.13. Mark Cheeseman was the Chief Operating Officer of the FEDG (Fraud, Error, Debt and Grants) directorate and Director of the GCFF from April 2020, reporting to Lyn McDonald who reported to the Cabinet Office Permanent Secretary. Mark Cheeseman led the design and launch of the PSFA in 2022 (outlined below) as the Interim Chief Executive Officer until he was appointed as CEO of the PSFA in May 2023. Between November 2019 and February 2020 Mark Cheeseman was seconded full time as a Special Advisor to the Australian Government to help build the Australian government response to public sector fraud, sharing the lessons learned and progress made in the UK. He returned to the UK in February 2020 and continued to advise the Australian government formally until August 2022.

5.14. In 2018 the Cabinet Office launched the Government Counter Fraud Functional Standard, which applied to all Government departments and their ALBs. The Counter Fraud Functional Standard was published in 2019 and updated in 2021.[412] The Government Counter Fraud Functional Standard was introduced to set the minimum standards for the management of counter fraud, bribery and corruption activity in Government organisations. Prior to this, there was no explicit counter fraud standard set, but Accounting Officers were (and remain) responsible for the management of public funds in accordance with the regulatory and proprietary requirements and principles contained within Annex 4.9 of Managing Public Money.[413]

The work of the GCFF between 2018 and 2020

5.15. After its launch, the GCFF continued to develop and promote its new counter fraud offering to departments (who ultimately own the fraud risk in their respective area) across Government and internationally. This work was focused on structural, long term change in government through the GCFP, and the Government Counter Fraud Functional Standard.

5.16. This included the publishing of promotional material outlining what the Government's Counter Fraud Functional Standard was and what assistance the GCFF could offer the departments in countering fraud by providing expert advice, developing capability, setting and assuring standards, monitoring fraud across Government and identifying where fraud could be found or prevented.[414] The GCFF also organised the first Counter Fraud International Symposium held in London in

[412] GRW/420 - [INQ000471032]
[413] GRW/421 - [INQ000279942]
[414] GRW/424 - [INQ000055871]

2018, a forum that would go on to form the International Public Sector Fraud Forum (IPSFF) involving the UK, US, Canada, Australia and New Zealand.

5.17. Work was also developed on how the Government could use data in order to combat fraud. In June 2019, the Cabinet Office and the Department for Digital, Culture, Media and Sport produced a 'Thought Paper' entitled 'Tackling Fraud in Government with Data Analytics – Starting the Conversation'.[415] This paper highlighted that the Cabinet Office was leading the development of the Government's counter fraud function's use of data to fight fraud and it was working with a number of public bodies to fight fraud in the form of recoveries, cost savings and the development and refinement of counter fraud systems. It also noted that work was being undertaken to coordinate a new Counter Fraud Data Analyst Community which would support the development of counter fraud analytics as well as developing and delivering best practice guidance,[416] skills guidance[417] and training[418] on how to use analytics in counter fraud based on experience from both the public and private sectors.

The GCFF during the pandemic

5.18. During crisis management situations, such as responding to the pandemic, the risk of fraud rises - this was the conclusion of the guidance developed by the International Public Sector Fraud Forum, led by the UK, and published in February 2020.[419] As early as 21 March 2020, calls to the National Fraud Intelligence Bureau had increased by 50% relating to various types of economic crime and there were already 35,000 malicious domains (websites with the aim of facilitating fraud).[420]

5.19. In the case of PPE procurement the use of direct award on the basis of extreme urgency and dealing with many new and untested suppliers to the market, many of whom were outside the UK, was an example of a crisis management situation. It is worth noting that all the PPE purchasing during the period of Cabinet Office's involvement in this strand of work, which ended on 31 July 2020, was by direct award.

5.20. As a consequence of the increased risk, on 16 March 2020, the GCFF reprioritised its work including by making its resource available to departments to help them

[415] GRW/423 - [INQ000477232]
[416] GRW/424 - [INQ000496910]
[417] GRW/425 - [INQ000496899]
[418] GRW/426 - [INQ000496921]
[419] GRW/427 - [INQ000055873]
[420] GRW/428 - [INQ000477910]

understand fraud risk.[421] This increased activity on COVID-19 focussed on building public awareness and sharing and promoting best practice guidance. It was based on learnings from work undertaken by the International Public Sector Fraud Forum (led by the UK and Australia) which emphasised the importance of prevention and that there was no one size fits all solution.[422] In turn, this guidance was used to inform guidance for the UK published on gov.uk on 26 March 2020 which set out the key principles for effective fraud control during emergency situations. The guidance was targeted at leaders and fraud experts in government bodies and local authorities that were administering emergency programmes on behalf of the Government.[423]

5.21. By 21 March 2020, the Chancellor had announced a spend of £342 billion in response to the COVID-19 pandemic. These funds were to be distributed through 27 programmes involving 8 central government departments, 408 local authorities and 414 NHS organisations. At the outset of the pandemic the GCFF intensified its work to support all departments and functions that were increasing their spending as a result of the package that had been announced by the Government. For example the GCFF developed additional resources such as the Counter Fraud Measures Toolkit and the Post Event Assurance Toolkit.[424] On 21 March 2020, Mark Cheeseman forwarded an email to me attaching a slide deck which set out the various ways in which the GCFF was setting itself up to work with the Government to understand and take action on the risk against COVID-19 related fraud across two primary workstreams covering Cross Sector Activity and Public Sector Activity and the types of services that they could support.[425]

5.22. In April 2020, the GCFF produced its Counter Fraud Measures Toolkit which was developed to assist public bodies in the design and the delivery of the various COVID-19 support packages. This toolkit features a range of countermeasures and solutions that might be deployed to reduce the risk of fraud and error in the design of the various COVID-19 support packages, including the use of third party countermeasures such as the due diligence tool 'Spotlight' (which provides various risk insights including whether a company is trading, showing financial weakness or has secured other public sector contracts in the past) and the fraud prevention and

[421] GRW/429 - [INQ000497016], GRW/430 - [INQ000477905]
[422] GRW/427 - [INQ000055873]
[423] GRW/431 - [INQ000496698]
[424] GRW/432 - [INQ000477240] - Counter Fraud Measures Toolkit, GRW/433 - [INQ000497002] - Post Event Assurance Toolkit
[425] GRW/434 - [INQ000471007], GRW/429 - [INQ000477910]

verification tool 'AppCheck' (a tool provided by the CO's National Fraud Initiative that provides address verification at the point of application). Moreover, it highlighted that the GCFF was on hand to assist departments.[426]

5.23. An early issue that arose was an increased threat in mandate fraud, where a fraudster will make a request that the details of a direct debit, standing order or bank transfer mandate are amended before payment in order to divert money into a fraudster's account. As a consequence of the increased threat of mandate fraud, the GCFF produced guidance for departments. This guidance advised departments to be alert to any requests to alter bank details and to be especially vigilant of such requests that were close to a payment deadline; to ensure that senior team leaders formally authorise any request to change bank details; and to regularly assess security policies.[427]

Fraud: PPE specific actions

5.24. In March 2020 the CoEx in GCFF, as part of its restructure to pivot towards COVID-19 fraud risks, set up an intelligence team to gather intelligence from across the public and private sector on COVID-19 with the aim of developing an overview of the fraud threat by monitoring the fraud landscape, collaborating across government, and informing the public sector response to fraud. This included collaboration with the National Crime Agency, DHSC and the GCF/comercial teams involved checking contracts for high value PPE and health service contracts, pre-award and scrutinising post-award to identify the risk of fraud occurring.[428] Combined with wider efforts by the DHSC fraud team, this contributed to over £139m in savings to the taxpayer through the identification of fraudulent (including suspected) contracts which were then terminated and the prevention of proposed contracts being signed. Of this, £77m was directly linked to the activity of the CoEx and was reported in the 2020/21 Government Efficiency Savings technical note.[429]

5.25. The demand for PPE increased rapidly in the early stages of the pandemic and the need to procure it at speed became an urgent concern. Due diligence checks were an essential part of the PPE procurement architecture during the pandemic. From 29 March 2020 these checks were undertaken by a specialist unit (the "Due Diligence Team") within the Markets and Suppliers team, part of the GCF (a

[426] GRW/432 - [INQ000477240]
[427] GRW/435 - [INQ000477926]
[428] GRW/436 - [INQ000496741]
[429] GRW/437 - [INQ000496740]

description of what these checks involved can be found in paragraph 4.433 of Section D). However, the turnaround time for these due diligence checks was between 24 and 48 hours. In April 2020, and upon the setting up of the Rapid Response Team (see paragraphs 4.469 - 4.475), the aim was to provide a service which would see the same due diligence checks completed, albeit in a timeframe of four hours (the 'Rapid Due Diligence Process'). The Rapid Due Diligence Process was only used for offers processed by the Rapid Response Team.

5.26. On 2 May 2020, the GCF commissioned the GCFF to provide advice on what additional checks should be included in a due diligence review process which sought to undertake due diligence checks in four hours. The four hour timeframe was selected to assist teams to conclude deals within a day, if necessary, reflecting the rapid pace at which purchasing decisions needed to be taken. In advice that was provided with urgency, the day after it was commissioned, the GCFF noted that:[430]

5.26.1. "Purchasing of PPE in support of the COVID-19 response faces significant fraud and irregular spending threats. This is due to:

- The pace at which purchasing is undertaken and the product deployed;
- The fact that in crisis management situations the risk of fraud increases;
- The complex international supply chains and purchasing markets.

5.27. The report went on:

5.27.1. "Fraud and irregular spending will be happening. The question is not whether, but how much - and how we can limit it. Intelligence collected in the context of the current, longer process demonstrates this. 106 referrals have been received related to Healthcare COVID spending. Examples of fraud related to PPE include:[431]

- Large payments being stopped due to hitting dormant or suspicious accounts;

[430] GRW/438 - [INQ000477927]
[431] While the examples provided by the GCFF are expressed as 'examples of fraud related to PPE', as is self-evident these examples are of fraud that were identified and prevented.

- Reports of companies failing to provide evidence of their ability to provide goods during pre-procurement stage;
- Companies who have failed due diligence checks overseas targeting the UK."

5.28. The GCFF provided a number of recommendations which included:

5.28.1. Utilising commercial tools such as 'Spotlight', 'FAME' by Bureau Van Dijk or the Police National Computer to provide insights that would inform due diligence decision making and ensuring that any information gleaned is recorded and stored securely in one place.

5.28.2. Ensuring that there is a clear audit trail for decisions where due diligence flags have been overridden and ensuring that all content regarding the overriding of due diligence decisions are recorded on the Mendix system. The GCFF also advised developing an effective feedback loop on goods that have been received by companies who were filtered through the Rapid Due Diligence Process, including feedback on the quality of goods or whether the company has simply behaved fraudulently or unethically.

5.28.3. Checks that have been removed or where not undertaken should be performed as soon as possible as part of 'post due diligence activity'.

5.28.4. Suppliers would not be paid upfront where possible and a mechanism to claw back irregular payments ought to be built into all contracts.

5.28.5. The Rapid Due Diligence process, including what steps were required both pre and post purchase and who was responsible for them, was to be urgently written up and was to clearly define the due diligence criteria that the Rapid Due Diligence process was mapping against and how this criteria was being checked. The GCFF recommended that the Rapid Due Diligence process be reviewed on a regular basis against intelligence received on PPE providers and on what represents the best value for money. There was to be clarity on who the overall owner of the regulatory risk was and it was assumed this was the Secretary of State for the DHSC.

5.29. The GCFF advice in its first paragraph stated that "this review and advice has been

provided in 24 hours with limited access to the proposed processes and details of the checks. The recommendations are confined to the remits of its limitations". The processes continued to change after GCFF had provided its advice. Further to this advice, the GCFF continued to engage with the GCF and provide further updates and recommendations on rapid due diligence support.[432]

5.30. On 23 June 2020 the GCFF supported the GCF in preparing a slide deck to address the earlier recommendation that the Rapid Due Diligence process should be mapped.[433] In late June 2020, the Cabinet Office team completed a handover to a DHSC team including relationships with the due diligence consultancies that had been supporting the Markets and Suppliers team. This included briefing on the enhanced due diligence process following implementation of certain recommendations of the GCFF team.

5.31. In July (with the report produced August) 2020, the GCFF worked with the GCF to review the status of the recommendations and advice provided, noting that, of the 17 initial recommendations made, 7 were taken up by the Due Diligence team and 10 were not.[434]

5.32. There were a range of reasons why some of the other recommendations in the GCFF advice were not taken up. For example, the recommendation to use a Bank Account Verification tool to identify high-risk bank accounts was not taken up because bank account checks were performed by DHSC (or their bankers) before transfers were made. The recommendation in respect of ensuring a clear audit trail in respect of due diligence flags that had been overridden was also not taken up by the GCF as the Due Diligence team in Markets and Supplies team were not responsible for 'overriding' any due diligence flags, or for removing any checks. Their involvement essentially ended once they produced input for a 'closing pack' (with due diligence concerns flagged) before that was handed over to the relevant Accounting Officer in DHSC. There is evidence in the minutes of the clearance board that issues were raised regarding the results of due diligence of a number of counterparties.[435] In some cases the board decided to endorse the transaction with the counterparty even though the status was 'Amber' as the goods were in demand or mitigation actions such as escrow arrangements were in place.

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[432] GRW/439 - [INQ000471014]
[433] GRW/440 - [INQ000477940]
[434] GRW/441 - [INQ000478820]
[435] GRW/406 - **[INQ000522285]** GRW/407 - [INQ000497263]

5.33. The recommendation on the use of 'upfront' and 'staged' payments was not taken up because payment was a matter that was dealt with by the relevant DHSC closing team. It is worth emphasising however, that while it was preferable to avoid 'upfront' and 'staged' payments, this did not align with the market and demand realities prevailing at the time.

5.34. The GCF did not take up the recommendation on the production of photos as evidence of the quality of goods being produced by certain suppliers, as this work was already being implemented by the Technical Assurance team. Similarly, the GCFF recommendation on a feedback loop on goods that had been received from companies who had been subject to Rapid Due Diligence checks was not taken up by the GCF as buying had largely ceased before such feedback could be obtained.

5.35. The recommendation on the adoption of a number of due diligence tools (including IBM's Financial Crimes Insight and Vocalink Corporate Fraud Insights) which would assist the Markets and Suppliers team in their due diligence work was also not taken up. While the GCF did attend a demonstration with a view to implementing some of these products, ultimately the decision was taken not to proceed, as, by June 2020, responsibility for due diligence was moved from the Markets and Suppliers team to DHSC.

5.36. On 4 May 2020, Chris Hall (who at that stage was assigned to the DHSC to assist on PPE procurement) requested that additional resource be assigned to assist the DHSC Counter Fraud team with a small number of potential fraud cases. Following contact from Mark Cheeseman, DHSC assigned an investigator from the NHS Counter Fraud Authority to assist DHSC with the investigation of potential frauds.

5.37. On 7 May 2020, GCFF was commissioned to work with colleagues in the Home Office, the Department of Work and Pensions, the DHSC and others to produce a paper for a meeting of the General Public Sector Ministerial Implementation Group ('GPSMIG', one of the four ministerial implementation groups which co-ordinated the Government's response to the pandemic between March and May 2020). This meeting was to consider work done to counter fraud during the pandemic and was to be held on 12 May 2020. GCFF produced a paper[436] which noted that:

[436] GRW/442 - [INQ000083562]

5.37.1. The GCFF had brought the public sector together to create new intelligence sharing arrangements which included work across traditional law enforcement and public sector boundaries.

5.37.2. GCFF had published guidance on key issues and controls for public bodies to use; and

5.37.3. GCFF had worked with banks and credit agencies to develop and launch two new fraud prevention tools and were piloting 5 further tools.[437]

5.38. The GCFF recommended that the GPSMIG required all departments to commit to Post-Event Assurance Activity, developing an action plan by the end of May 2020, and stated that more could be done on investing in intelligence sharing, exploring new legislative powers and commissioning a review on lessons learned. The main recommendation of the GCFF to the GPSMIG on 12 May 2020 was to bring all COVID-19 fraud activity together in a new Ministerial Board, chaired by Cabinet Office, HMT and the Home Office.[438]

5.39. This GPSMIG agreed to the recommendations on tackling the public sector fraud threat as a result of COVID-19. The actions included:

5.39.1. ALL DEPARTMENTS with the support from the CABINET OFFICE, to commit to post event assurance activity and to develop an action plan by the end of May.

5.39.2. CABINET OFFICE to work with other departments to invest in intelligence sharing.

5.39.3. CABINET OFFICE to explore any new legislative powers that might be needed, or existing legislation to be better understood and used.

5.39.4. CABINET OFFICE to commission a review of lessons learned.

5.39.5. CABINET OFFICE to oversee activities to tackle COVID-19 related fraud in a new Ministerial Board, to be chaired with HM TREASURY and the HOME OFFICE.

[437] An update on the status of the implementation of the tools is provided at GRW/439 - [INQ000471014]
[438] GRW/443 - [INQ000083567] GRW/444 - [INQ000272906], GRW/445 - [INQ000083623]

5.40. DHSC subsequently undertook Post Event Assurance activity as required by the GPSMIG. This included the provision of a detailed action plan setting out how they were tackling identified fraud risks in their areas of spending.[439] DHSC also undertook a fraud loss measurement exercise to estimate the likely level of loss to fraud across PPE procurement. This fraud loss measurement exercise was subsequently reviewed by a cross government expert advisory/oversight group. The loss measurement was divided by DHSC into sampling based on what were considered high risk contracts and sampling on lower risk contracts. The sampling on higher risk contracts was deemed a high-quality, thorough and robust piece of work. However, the work on lower risk contracts and existing suppliers was not to the same quality. Due to this, and the fact that the overall sample was not a completely random sample it was concluded the exercise did not meet the government standard for fraud measurement.[440]

5.41. The Cabinet Office also established a new Ministerial Board, chaired by the Cabinet Office and the Home Office (with core membership from other government departments) to oversee the response to COVID-19 related fraud, the Fraud Ministerial Board (FMB).

5.42. The FMB was co-chaired by Lord Agnew (the Minister of State) and James Brokenshire (Security Minister).[441] The FMB was to "coordinate and advise on the response to fraud for COVID-19 with a focus on the public sector". It reported, if required, to the newly formed COVID-19 Ministerial Board(s) and was to meet monthly to ensure that the recommendations outlined were given appropriate consideration in a timely manner. In particular the FMB was to:

5.42.1. Gain an understanding of what fraud and irregularity there was in the COVID-19 support packages, repurposed grants and increased demand and if there was any further policy action needed as a result.

5.42.2. Review the use of existing legislation and consider the need for new legislation for public bodies, wider law enforcement and the banking sector to counter fraud in response to COVID-19;

5.42.3. Review the opportunities to increase fraud intelligence sharing between banks, police and public sector post COVID-19; and

[439] GRW/446 - [INQ000497006]
[440] GRW/447 - [INQ000497017]
[441] FMB's approved terms of reference which were agreed at the first meeting of the board on 16 July 2020 is at GRW/448 - [INQ000477265]

5.42.4. Oversee a lessons learnt review of the public sector fraud response to COVID-19 to inform future emergency management responses.

5.43. On 17 June 2020, the GCFF provided a COVID-19 Fraud update to Lord Agnew.[442] This update identified the key areas for fraud risk which included PPE and medical supplies and Test and Trace. The annexes to the COVID-19 Fraud update provided further detail on the manner in which fraudsters targeted PPE and other medical supplies as well as a summary of the fraud threats encountered by Test and Trace.[443]

5.44. On 29 June 2020, the GCFF updated the FMB on the COVID-19 fraud landscape noting that: "[T]here is a steady flow of intelligence relating to the use of HMG branding and schemes as a hook to defraud the public, and we have seen iterations of this during COVID-19, from fake test kit sales to false text messages purportedly from HMRC or other agencies." This update further observed that Government Departments had implemented additional measures to mitigate COVID-19 fraud, for example: work by HMRC on fraud investigation and compliance; measures by DWP on their risk and intelligence service; work by DHSC to introduce new flows of intelligence with regards to the supply of PPE and medical equipment; and work by BEIS on the risks in the Bounce Back Loan Scheme.[444]

5.45. On 21 January 2021, the GCFF provided an update to Lord Agnew which noted that "the threat landscape continues to evolve and we have evidence that the lessons learnt during the earlier phases of C-19 are not being applied to new or extended areas of spend. A few new areas of risk are emerging including vaccine related fraud. These types of fraud risks are moving beyond financial impact to include human harm and reputation impact that could, for example, directly harm individuals and undermine confidence in the UK vaccine distribution."[445]

5.46. Throughout 2021, the work of the GCFF continued and was mainly focused on work surrounding Post-Event Assurance and in respect of Business Bounceback Loans.

The Public Sector Fraud Authority

5.47. In February 2022, and in response to concerns over the level of fraud during the COVID-19 pandemic and the lack of a coordinated response, work commenced on

[442] GRW/449 - [INQ000477258]
[443] GRW/450 - [INQ000477257]
[444] GRW/451 - [INQ000497009]
[445] GRW/452 - [INQ000477271]

mobilising a new Public Sector Fraud Authority (the 'PSFA'). The intention to create this authority was announced in March 2022 and a taskforce was convened to oversee its implementation.

5.48. Funding in the total sum of £24.7m over three years for the PSFA was announced in the Chancellor's 2022 Spring Statement.[446] The PSFA was launched on 3 August 2022.

5.49. The PSFA replaced the Counter Fraud Centre of Expertise (CoEx) as the Government's centre of expertise for GCFF reporting to both HM Treasury and the Cabinet Office. It advises Cabinet Office and HM Treasury on levels of fraud, trends and performance in ways of dealing with it, uses data to scrutinise public body performance and provides expert advice on assurance and key counter fraud activities, and builds and delivers targeted support services to departments. Its first annual report was published in November 2023.[447]

The treatment of suspicious contracts

5.50. The Inquiry has requested specific detail by way of a list of bids or contracts which the Cabinet Office treated as fraudulent or suspicious. In respect of PPE, the Inquiry requests the number of contracts treated as suspicious and the amount of money lost as a result of suspicious or fraudulent contracts.

5.51. All suspected fraudulent approaches were referred to the relevant counter fraud officer in DHSC. As such, Cabinet Office did not maintain such a list.

5.52. Cabinet Office does not hold information on the number of prosecutions or successful convictions arising from bids or contracts that were treated as suspicious.

[446] GRW/453 - [INQ000471048]
[447] GRW/454 - [INQ000477281]

6. SECTION F: INTERNAL AND EXTERNAL REVIEWS

6.1. In this section, I detail the various reviews and audits that have been undertaken and commissioned by the Cabinet Office which seek to establish the areas in which procurement procedures, policies and governance can be improved and set out various lessons that can be learned from the experience of procurement during the pandemic. I also refer to the work done and continuing to be done to implement the various recommendations from those review exercises.

6.2. The Cabinet Office sought to learn lessons and identify opportunities for improvement throughout the pandemic. This included less formal, internal exercises and the lessons implemented from these as the approach to responding to the pandemic evolved. Two examples of such work are also included in this section alongside further details of other exercises disclosed to the Inquiry. The section concludes with a summary of the GCF training programme and how this seeks to respond to lessons learned from the response to the pandemic.

Internal Exercises

6.3. As is explained throughout this statement, procurement during the pandemic was undertaken against the backdrop of unprecedented, highly unique and challenging market conditions. The letting of so many contracts on an urgent basis was subject to scrutiny. There was also criticism of the way in which public contracts had been entered into at a time of crisis, using emergency provisions in the regulations, and using non-standard routes to market as a result of critical need and great shortages of supply. Much of the media attention (most notably a Newsnight segment broadcast in November 2020 and a Panorama investigation broadcast in March 2021) focused on the letting of direct award contracts pursuant to Regulation 32(2)(c) of the 2015 Regulations and whether the choice of supplier was in some way defective.

6.4. I have explained at paragraph 1.30 above 3 examples of contracts awarded to, on the face of it, unusual suppliers but which, after review, were understandable.

6.5. A further criticism was that the High Priority Lane was susceptible to 'cronyism' with offers being favoured to suppliers who had established 'political connections'. The GCF was responsive to these criticisms and supported a two-phase review by the Government Internal Audit Agency (GIAA). Its clear findings are set out at paragraphs 6.13-6.23 (including that the review had "not identified…evidence to

suggest…that the contractual parties received preferential treatment.)". The GCF was continuously monitoring and assessing procurement with a view to understanding if improvements could be made. For example, I asked for a comparative price analysis of PPE purchasing that identified the prices paid specifically for goods purchased through the HPL.[448] Prices paid for products bought through the HPL lane were plotted against the price analysis for all PPE purchased. In some categories, HPL goods were cheaper; in others slightly more expensive and others showed no discernible pattern. This analysis was limited as while the specification of some categories such as "IIR mask" is precise, thus making pricing directly comparable; other categories such as "gown" are less precise, covering a wide range of products at different price points. Examples are sterile or non sterile gowns, gowns made of different materials and gowns made for sessional or single use. Price comparison is thus more difficult.

6.6. A more detailed pricing analysis was carried out by GIAA and is described and exhibited in paragraphs 6.19-6.23 below. Additionally an exercise was run to see if the 'drop out rate' of offers coming from the HPL and from other sources was markedly different in a way that might indicate favouritism in the processing of offers after initial screening. The results of this exercise are set out at paragraph 4.4924, and suggest that HPL offers were not favoured over non-HPL offers when checking for technical compliance or counterparty suitability.

6.7. Further, at my direction and throughout the pandemic, the GCF undertook research on purchasing activity. This included looking at whether some suppliers had been unfairly treated and overlooked by the PPE Buy Cell, as was reported in some critical press stories and by broadcast media. I as GCCO instructed my team to investigate these allegations.

6.7.1. One such allegation (shown on the BBC's Panorama) involved a company based in Yorkshire, which offered PPE 'but didn't get a contract'. On investigation the records show that there were problems with the CE marking on the goods put forward by this company. The certification body for the CE marking issued a statement on 3 April 2020 that while it was a certified body for some goods these did not include PPE. This made it impossible for the PPE Buy Cell to purchase goods that had been certified by this body.

[448] This review was completed on 17 June 2020 and is exhibited at GRW/455 - [INQ000478816] (relevant slides are 14, 23, 29 and 32).

6.7.2. Another supplier, featured on BBC Newsnight, contacted the PPE Buy Cell with an offer of KN95 masks (not acceptable to the NHS) and other products. These other products did not have the full package of information needed to pass Technical Assurance (such as test reports and certificates of conformity).

6.7.3. The Daily Mail ran a story featuring a Hong Kong based textile dealer who suggested that the approach taken by the government to buying PPE was flawed. He made offers to the PPE Buy Cell, but did not support these offers with the correct documentation, claiming that instead he would undertake random product testing in China but away from the manufacturer's premises. This process was not acceptable to the PPE Buy Cell.

6.7.4. Other suppliers had made similarly unacceptable offers of product that we could not validate, or refused to accept DHSC's standard contract terms regarding product liability.

6.8. As well as the formal reviews that are detailed below, it is important to emphasise that the preparation of answers to press inquiries and parliamentary questions, and the overall experience of managing complex and urgent procurement concerns at a time of national crisis, meant that there was an on-going process of reflection and lessons were continually being learned as the pandemic progressed.

6.9. An example of this on-going reflection can be seen in the work done by CTT colleagues on Project Audiverimus. Work on this internal review commenced in May 2020[449] and its purpose was 'to capture the GCF's involvement in the PPE response particularly in preparation for any review of the Government's response to Coronavirus that might take place.' The review was to cover:

6.9.1. Where, when and why the GCF was involved in particular workstreams;

6.9.2. The precise role and responsibilities of the GCF outlining exactly where departments were responsible and where the GCF was responsible;

6.9.3. Timelines and key decision points; and

6.9.4. Areas where the GCF is seen to have succeeded and areas where there are lessons to be learned.

[449] GRW/456 - [INQ000409851]

6.10. This review, undertaken at the height of the pandemic, was a living, on-going review exercise contributed to by many officials working within GCF. Its aim was to capture events fresh so that institutional memory could be preserved in the event that contributors moved onto different roles. As it was commissioned strictly as an internal review exercise, the contents of the report were not published.

6.11. While the Audiverimus report does include useful reflections on the work of the GCF at that time, as a 'living' and 'on-going' review, this report has certain limitations. The parts of the review that are relevant to procurement of medical equipment and supplies during 2020 and 2021 are not comprehensive, and the report is one person's view of the key areas of work at a specific moment in time. As will be appreciated, during the pandemic circumstances changed frequently and often very quickly, and the contemporaneous nature of the reflections in Audiverimus need to be viewed in that light. For example, the report makes reference to the EU's ability to coordinate a rapid tender process compliant with standard EU procurement Regulations. While this was a reasonable sentiment at the time that it was authored, it does not (nor could it) have anticipated the difficulties that that particular EU procurement process eventually ran into.[450] In fact the early collaborative procurement exercises that were run by DG Santé either received no or no compliant bids, or in some cases resulted in awards of very large contracts to SMEs who allegedly proved unable to deliver in full.[451]

6.12. In mid-May 2020, the Prime Minister also commissioned Alex Chisholm to produce a short note which looked at how the government had learned from the twelve weeks prior procurement activity. The note was prepared by GCF and shared with No.10 on 20 May 2020, alongside a cover note from Lord Agnew.[452] The learnings identified in the note include:

6.12.1. The Functional model is providing benefits and should be reinforced;

6.12.2. Public sector organisations need to be ready to procure at scale;

6.12.3. Procurement requires strong leadership, an appetite for risk and a holistic view;

6.12.4. Government needs to provide clear instructions to suppliers;

[450] GRW/457 - [INQ000477291]
[451] An undated draft copy of the Audiverimus report is at GRW/456 - [INQ000409851]. This is understood however to be the final iteration. The work was superseded by other audits such as the NAO and GIAA work discussed below.
[452] GRW/458 - [INQ000496718], GRW/459 - [INQ000496717]

6.12.5. The Spending Control system adds value but could be bolstered;

6.12.6. Government needs to continue to monitor and support strategic suppliers;

6.12.7. Political direction and leadership roles and responsibilities need to be clearer; and

6.12.8. Lack of IT integration and conformity across Government has been a problem.

The Government Internal Audit Agency Review of awarding PPE contracts – Phase 1

6.13. In August 2020 I agreed with the Permanent Secretary to commission an independent audit of some contracts that were attracting particular attention in the press. A particular focus of this audit was to investigate the claims of "cronyism".

6.14. On 11 August 2020, the Cabinet Office commissioned the GIAA to assess the design and effectiveness of controls that were in operation in the early stage of the pandemic. This targeted review sought to inform lessons learned by providing independent and objective advice to the Cabinet Office's Accounting Officer on the adequacy, effectiveness and proportionality of controls it was responsible for designing, establishing and operating when assisting DHSC in procuring PPE during the height of the COVID-19 pandemic.

6.15. The review was divided into two phases. Phase 1 set out to assess six contracts which, at that time, were the subject of some persistent media and legal scrutiny and provided key findings on whether they were awarded in adherence to documented controls and guidance, including the declarations and management of conflicts of interests and due diligence of companies and their products. One question asked by this review was if there was any evidence that these vendors were preferred over others.

6.16. The contracts considered as part of phase 1 of the GIAA review were:

6.16.1. PestFix Limited – Contract Number CO937, Purchase Order 546421;

6.16.2. Ayanda Capital Limited – Contract Number CO792, Purchase Order 546455;

6.16.3. Clandeboye Agencies Limited – Contract Number CO821, Purchase Order 548514;

6.16.4. P14 Medical Limited – Contract Number CO919, Purchase Order 547803;

6.16.5. Luxe Lifestyle Limited – Contract Number CO906, Purchase Order 546562; and

6.16.6. Meller Designs Limited – Contract Number CO901, Purchase Order 546916.

6.17. Phase 1 of the GIAA report, published on 1 October 2020, concluded that:

6.17.1. While the audit trail evidencing effective implementation of controls was not as robust as would be expected during non-covid times, the evidence suggested that the majority of key controls had been applied. The main weaknesses arose in the audit trail of due diligence checks, in that, if there was an issue as to the financial standing of a supplier, there was not always an audit trail of how such issues were resolved.

6.17.2. There was no evidence that controls were applied any differently to contracts that were let via the High Priority Lane, or that contractual parties received preferential treatment.

6.17.3. Limited documentation on due diligence checks was retained on the Mendix system. While the report did not impute a cause, we believe this situation occurred because the system relied on caseworkers to upload documentation, rather than this being a specific requirement.

6.17.4. There could have been clearer evidence of decisions that were made by the Clearance Board (the group of senior officials from various departments which would review all contracts that had a total value of £5m and above, reporting to the DHSC). For contracts of £5m and above that were awarded prior to the creation of the Clearance Board, the audit trail for their endorsement was inconsistent and limited, albeit that some information relating to the negotiation of such contracts was retained in a DHSC ‘deal pack’.

6.17.5. There were inconsistencies in terms and conditions that were used in PPE contracts.

6.18. The GIAA’s phase 1 recommendations were primarily directed towards adequate record keeping and included recommendations that:

6.18.1. A full audit trail for all contracts awarded should be maintained. This included contracts let via the High Priority Lane and contracts let prior to the creation of the Clearance Board. The details of all conflicts of interests, new supplier forms and details on how any concerns flagged by due diligence have been mitigated should also be recorded;

6.18.2. Cabinet Office should collaborate with other government departments such as DHSC to evidence together their compliance with 'Procurement Policy Note – Responding to Covid-19'.

6.18.3. GCF should keep written justifications on the award of contracts that satisfies tests required for reliance on Regulation 32(2) for direct awards and Regulation 72(1) for modifying contracts.[453]

The GIAA Review – Phase 2

6.19. Following the first review, I agreed with the Permanent Secretary to commission a further review considering the same issues as phase 1, looking into a further six contracts which had also attracted media attention. Phase 2 also produced data analysis of pricing of PPE contracts along with recommendations on how processes could be improved and risks mitigated in the event of a future pandemic. Four of the contracts assessed were chosen on the basis that it was believed that they presented certain risks. GIAA then selected a further two contracts at random.

6.20. The contracts considered in phase 2 were:

6.20.1. Saiger LLC – Contract Number DHSC/12767 – Purchase Order FCP1181;

6.20.2. Robert Housely Limited – Contract Number CO10959 – Purchase Order 547344;

6.20.3. Dylan Imports Limited – Contract Number DHSC/3679 – Purchase Order 547535;

6.20.4. Initia Ventures Limited – Contract Number DHSC/792 – Purchase Order 546365 (randomly selected);

6.20.5. MGP Advisory Limited – Contract Number DHSC/5538 – Purchase Order 546469; and

[453] A copy of 'Targeted Review of Awarding of PPE Contracts (Phase 1 Report)' is at GRW/35 [INQ000478823].

6.20.6. Purple Surgical – Contract Number CO652 – Purchase Order – 546146 (randomly selected).

6.21. The phase 2 findings were largely the same as phase 1. The phase 2 report, published on 16 February 2021, observes that:

6.21.1. While there was no evidence that controls had been applied differently to suppliers that were approved via the High Priority Lane, at the time of GIAA's review there was no definitive comprehensive database documenting which suppliers came through this lane and who was the source of the referral;

6.21.2. Limited documentation was retained as to what was being done to resolve due diligence issues that had been identified. Some counterparties had due diligence checks done on them, but others did not, therefore Cabinet Office should consider being clear about what processes and checks are to be performed on the counterparties and by whom; and

6.21.3. In respect of pricing analysis, the GIAA observed that, as would be expected, prices of PPE peaked in April / May of 2020. However, it also identified a number of outlier contracts with particularly high prices awarded after the peak period. GIAA advised that the Cabinet Office follow up with these contracts to ensure that appropriate value for money was obtained.

6.21.4. Within the limitations of its pricing analysis, GIAA compared prices achieved for purchases made via the HPL, non-HPL and SCCL routes. Of 10 categories analysed, the GIAA considered that the HPL offered the cheapest average price per unit of the 3 routes for 4 categories: coveralls, FFP3 respirators, IIR masks and safety goggles. The HPL was also cheaper than the non-HPL (but more than the SCCL) for 2 more categories: gowns and face shields. Finally, the HPL was cheaper than the SCCL, but more than the non-HPL, for a seventh category: FFP2 respirators. In summary, on the GIAA's detailed analysis, the HPL only provided the most expensive average price per unit for 3 categories; gloves, aprons and body bags.

6.22. Importantly, this review confirmed a partial finding from the Phase 1 review: "Further,

we have not identified, on the basis of work performed to date, evidence to suggest that these contracts followed different processes or that the contractual parties received preferential treatment."

6.23. As was the case in phase 1, the GIAA's phase 2 recommendations were also largely focused on adequate record keeping.[454]

National Audit Office Reviews

6.24. While setting out the various internal reviews that were commissioned from within the Cabinet Office, it is important to highlight the various external reviews undertaken by the National Audit Office (the 'NAO'). These were:

6.24.1. 'Overview of the UK government's response to the COVID-19 pandemic', published May 2020;

6.24.2. 'Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19', published on 30 September 2020;

6.24.3. 'The supply of personal protective equipment (PPE) during the COVID-19 pandemic', published November 2020;

6.24.4. 'Investigation into government procurement during the COVID-19 pandemic', published on 26 November 2020;

6.24.5. 'The government's approach to test and trace in England – interim report', published December 2020;

6.24.6. 'Initial learning from the government's response to the COVID-19 pandemic', published May 2021;

6.24.7. 'Test and trace in England – progress update, published June 2021; The government's preparedness for the COVID-19 pandemic: lessons for government on risk management', published November 2021; and

6.24.8. 'Investigation into the management of PPE contracts', published in March 2022.

6.25. The list of documentation which the Cabinet Office sent to the NAO to assist with the authoring of these reports has been disclosed to the Inquiry.

[454] GRW/36 [exhibit to follow].

The First Boardman Review

6.26. In October 2020, the Government Legal Department, working with the support of the Cabinet Office's Propriety and Ethics team, undertook a review to establish the facts surrounding the award of a communications contract with a value of £840,000 to Public First Limited in March 2020 by the Cabinet Office. This fact finding exercise was precipitated by a claim for Judicial Review brought by the Good Law Project on 10 July 2020 and was extended to consider four other Cabinet Office communications contracts with values of £112,000, £280,000, £900,000 and £3m, awarded in March and April of 2020, upon the commencement of a second Judicial Review claim in respect of a communications contract to support No.10 in media analysis with a value of £900,000 which was awarded to Hanbury Strategy and Communications Limited in April 2020. The High Court held that while the Public First contract was awarded properly under Regulation 32(2)(c) of the 2015 Regulations, it was awarded in circumstances which gave rise to apparent bias. In January 2022, the Court of Appeal overturned this decision and held that the contract was awarded lawfully to Public First. The Good Law Project was refused permission to appeal to the Supreme Court. A settlement was reached between the parties in respect of the case relating to the award of the contract to Hanbury Strategy and Communications Limited.

6.27. Sir Nigel Boardman, a former partner with the law firm Slaughter and May and non-executive director and the former chair of the Audit and Risk Committee of, what was then, the Department for Business, Energy and Industrial Strategy (BEIS), was appointed to undertake an independent expert review of the preliminary findings of that fact-finding exercise ('Boardman 1').

6.28. Boardman 1 considers three topics: existing procurement law and policy for contracting in a time of crisis; the Cabinet Office's own process and governance in respect of law and guidance; and the management of actual or perceived conflicts of interest in a procurement context. 28 specific recommendations were made covering a number of broad themes which include, among others:

6.28.1. Ensuring that any guidance that is issued to Departments on urgent procurement in times of emergency is shared immediately with each business unit within a department;

6.28.2. Undertaking an assessment of commercial training needs for staff within various business units and for further such training to be developed and

made available to staff;

6.28.3. The streamlining of certain processes including through the production of a 'beginning-to-end' standardised contract check sheet, the allocation of a single point of contact for each contract, visualisation flow-charts of the procurement processes for different purchasing routes and a searchable, centralised Cabinet Office contracts register; and,

6.28.4. The management of conflicts of interest including the provision of further training and guidance on conflicts and the strengthening of the Cabinet Office's model for the management of conflicts following an 'identify, prevent, rectify' model.

6.29. Boardman 1 did not consider reforms to procurement law. Reform of procurement legislation was already underway at that point, further detail of which is provided in Section G of this statement.

6.30. Boardman 1 was published on 8 December 2020.[455] All of Sir Nigel's 28 recommendations were accepted by the Cabinet Office.[456]

6.31. On 14 December 2020, Alex Chisholm, the Civil Service COO and Cabinet Office Permanent Secretary, and Julia Lopez MP, Parliamentary Secretary for the Cabinet Office, wrote to senior leaders in the Cabinet Office drawing their attention to Sir Nigel's recommendations particularly in respect of proper record keeping, reminding them that "it is the responsibility of senior leaders to ensure that their teams have the capability, understanding and support to follow the proper process, even in the most challenging circumstances".[457]

6.32. The Cabinet Office Audit and Risk Committee ('COARC') had oversight of the implementation of all of the recommendations in Boardman 1.[458]

6.33. The implementation of Sir Nigel's recommendations was dependent on support from a number of different sources, for example those aspects of Boardman 1 which were of relevance to the Crown Commercial Service.[459] On 11 January 2021, CCS reported that they were working to review guidance provided to departments on processes for awarding contracts under framework agreements and Dynamic

[455] GRW/460 - [INQ000055888]
[456] GRW/461 - [INQ000471039]
[457] GRW/462 - [INQ000477944]
[458] GRW/463 - [INQ000477269]
[459] GRW/464 - [INQ000471030]

Purchasing Systems and that it would undertake an internal review of its processes and guidance in relation to the progression of framework and DPS procurements and would discuss and agree any recommendations with policy colleagues.[460]

6.34. By June 2021, 24 of the 28 recommendations in Boardman 1 had been implemented.[461]

6.35. An update on progress on implementation of recommendations is provided in Roger Hargreaves' corporate witness statement to Module 1 of the Inquiry, dated 1 February 2023.[462]

6.36. It is also important to state that, in light of Boardman 1, the Cabinet Office also invested in further improvements to the commercial team in the Cabinet Office which included, among other things:

6.36.1. Strengthening commercial controls via Budget Delegation letters, Budget Rules and Corporate Management Statements and integrating departmental Information Assurance and government Learning and Development controls into the Cabinet Office Commercial team as well as standing up a departmental control for professional services;

6.36.2. Establishment of regular engagement with transactional directors on 'Gold' contracts with regular 'challenge sessions' on contract performance; and,

6.36.3. The development of a Heads of Commercial forum with improved directorate communications, aligned training capability and an improved central team providing business operations support to the directorate.

The Second Boardman Review

6.37. On 11 December 2020, a proposal outlining the structure of an independent review into procurement during the pandemic was produced.[463] It was proposed that this review would examine 'the key qualitative, cultural and cross-cutting issues which remain under-scrutinised' and that such a review would assist the GCF, government departments and the Prime Minister 'in assessing honestly what underlying

[460] GRW/465 - [INQ000477270]
[461] GRW/466 - [INQ000105860]
[462] GRW/467 - [INQ000145912]
[463] GRW/468 - [INQ000409849]

problems there might have been and what would be helpful mitigations or improvements for the future.'

6.38. The second Boardman review was commissioned by the Prime Minister, Boris Johnson, and the Cabinet Secretary and considered procurement activities in key areas of the Government's response to the COVID-19 pandemic from the period 1 March 2020 to 1 December 2020 ('Boardman 2'). Boardman 2 built on investigative work that was already being done in this area including Boardman 1 and the investigations into government procurement that had been conducted by the NAO, outlined above.

6.39. Boardman 2 was intended to be a 'short and targeted' exercise which reviewed some of the circa 8,000 contracts that had been awarded by Government in this period and it considered the following areas:[464]

6.39.1. PPE for the NHS and social care;

6.39.2. Ventilators for clinical use;

6.39.3. Goods and services relating to vulnerable persons;

6.39.4. Services for Test and Trace; and

6.39.5. Vaccines and associated services.

6.40. The review was completed between January 2021 and March 2021. In this time, Sir Nigel Boardman interviewed a number of officials within the Cabinet Office.[465]

6.41. Recommendations were made across five broad themes of preparedness and strategy, organisational structures, resourcing, purchasing and governance and regulation. Boardman 2 noted that: "It is of course true that this country has not experienced a pandemic of the seriousness of COVID-19 for a century and it is therefore understandable that pandemic preparedness was not a high priority. The government will need to consider, as mentioned above, the likelihood of a further pandemic in the foreseeable future. Bearing this in mind, it is nonetheless incontrovertible that some of the challenges encountered in procurement could have been mitigated had the Government had more fully formed contingency plans and/or taken earlier action (either as preparation or in response to the rising threat of COVID-19). National resilience to future pandemics needs to be strengthened in

[464] GRW/469 - [INQ000477273]
[465] GRW/470 - [INQ000477272]

every area, including in stockpiles, supply chains (including sovereign manufacturing capability) and purchasing frameworks. Risk management should be prioritised as a proper cross-government profession to enable Government to respond to rising risk levels." [466]

6.42. The report noted that data and modelling was crucially important in judging how to respond to the pandemic. It highlighted good practice evident in the way government used data to respond to the fluidity of the pandemic, particularly in respect of: winding down the ventilator challenge as planning assumptions (and knowledge of existing stock) matured; switching from central delivery of food parcels for the clinically extremely vulnerable to supermarket food slot priority and local government support; and reviewing the expansion of Test and Trace facilities as demand became clearer. It highlighted that data modelling would "need to be interpreted with considerable judgement and awareness of [its] limitations. In addition, while direct awards under the procurement regulations enabled a swift response, teams should plan for an early transition to competitive procurement wherever possible."

6.43. Boardman 2 also made recommendations where the pandemic exposed some structural challenges that may have been a barrier to effective procurement. Sir Nigel suggested that "Central government should look to ensure its systems are compatible, and that its commercial teams are structured in the most effective way to target resources where needed, including being scalable in a crisis. I believe it will be necessary to review the way procurement is done in the health sector in times of crisis, with particular reference to the position of SCCL. Consideration should also be given to how to best ensure the privately-led social care sector can learn from the challenges of sourcing PPE, and properly prepare itself for a future challenge on this scale. In addition to a cross-government risk management profession, I also recommend better alignment to the Government Analysis Function in respect of data modelling and analytics."

6.44. Further, the report makes recommendations in respect of resourcing, including planning for the most appropriate structure and governance for commercial teams and ensuring sufficient expertise is in place.

6.45. Sir Nigel concluded that he had "not seen evidence that any contract within the scope of the review was awarded on grounds of favouritism… however, factors

[466] GRW/37 - [INQ000055876]

which may have encouraged such a suspicion… are:

6.45.1. the use, in relation to PPE, of a fast track email address available to members of parliament and others (which was initially referred to as the VIP lane);

6.45.2. the time taken to publish contracts awarded during the crisis;

6.45.3. lack of public understanding of the regulation 32 emergency procurement procedure;

6.45.4. the prices paid for emergency purchases, which were higher than market prices in non-pandemic times;

6.45.5. the failure (or perceived failure) of some of the purchased stock to be fit for use;

6.45.6. incomplete record keeping, including in relation to conflicts of interest; and

6.45.7. certain counterparties being associated with the Governing party."

6.46. Boardman 2 was published on 7 May 2021. The Prime Minister accepted all 28 recommendations.

Implementation of Boardman 2

6.47. After the publication of Boardman 2, work to implement Sir Nigel's recommendations commenced in earnest. Very shortly after publication a cross-Government Boardman Review Implementation Board (the 'Implementation Board') was convened.[467] Alex Chisholm had overall oversight of the Implementation Board and Clare Gibbs was the director who had oversight of implementation of recommendations relevant to the Cabinet Office.

6.48. On 30 June 2021, Alex Chisholm gave a further progress update on the work being undertaken by the Implementation Board to implement the recommendations of Boardman 2.[468] This update noted that there was confidence that each recommendation was on track to be delivered satisfactorily. However, at this time, there was an increase in incidence of COVID-19 and the Prime Minister was asked

[467] GRW/471 - [INQ000471031]; GRW/472 - [INQ000477945]
[468] GRW/473 - [INQ000477947]

whether he agreed to accelerating the pace of implementation of the following workstreams:

6.48.1. Working with DHSC to put the team responsible for procurement of PPE closer to the people who use it within NHS England & Improvement;

6.48.2. Compiling a register of civil servants who have previous consultancy experience that can be called upon at pace during crisis;

6.48.3. Reviewing aspects of the commercial function which aims to ensure that commercial resources and expertise can be deployed at pace and with greater efficiency during a time of crisis;

6.48.4. Developing a contingency plan for PPE that can be switched on when needed to provide full coverage across the health and social care sector; and

6.48.5. Working with the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and DHSC to review PPE stockpile requirements and management for a broader range of diseases other than influenza, and for non-hospital settings.

6.49. On 21 July 2021, a progress update on the implementation of Boardman 2 was provided to the chair of the Public Administration and Constitutional Affairs Committee. The update notes that, as of July 2021, there were developed implementation plans in place for 15 of the 28 recommendations and work had commenced on their implementation against agreed timelines. It was anticipated that 10 recommendations would be implemented by the end of September 2021. The other 13 recommendations were also in progress but the delivery plans were still in development and it was expected that, because those particular recommendations were dependent on the onboarding of additional resource, they would take longer to implement.[469]

6.50. On 10 August 2021, the CCS produced a review setting out the various strategic actions that would be taken to implement recommendation 11 ("There is a need for the Crown Commercial Service to review whether and how best to broaden the scope of its products and services in a crisis situation to maximise the impact of its skilled resources"). This report suggested that the implementation of recommendation 11 would be achieved by ensuring that the CCS had early and

[469] GRW/474 - [INQ000477948]

ongoing awareness of strategic commercial and procurement challenges in times of crisis. The report suggested a number of different actions which CCS would take to ensure the implementation of recommendation 11 including seeking early and on-going intelligence from the Civil Contingencies Secretariat to assess what commercial role would be needed in a crisis and ensuring that business resilience plans are up to date.[470]

6.51. In February 2022, the Government Internal Audit Agency (GIAA) reported that some progress had been made against the accepted recommendations and that 8 of the recommendations were complete. However, 13 had gone beyond their planned implementation date and 2 were at risk of not meeting their planned implementation date.[471] Following this, the Implementation Board was stood down and the relevant teams across government took responsibility for completing agreed tasks as part of normal business.

6.52. On 22 March 2024 GIAA reported that, of the remaining recommendations, two are agreed as outstanding/open and are being tracked until complete. Six in DHSC were reported as closed after consideration by DHSC Audit and Risk Committee in February 2024 although GIAA has not yet done separate confirmation work.

Lessons from COVID-19 Procurement - Conclusions from Government Auditors around the World

6.53. In November 2021, a short internal review analysing the conclusions of a number of Supreme Audit Institutions (the bodies responsible for ensuring that government's financial accounts are accurate and that public money has been spent effectively) ('SAIs') was undertaken by one of my directors, Chris Hall. This review drew on reports produced by the SAIs of large industrialised countries like the UK with similarly developed healthcare systems. The report is exhibited.[472]

6.54. The review considered the conclusions of various SAIs in respect of Preparedness pre-pandemic; Demand; Market conditions; Procurement processes; Prices paid; Quality; Outcomes; and Conclusions and lessons for the future. The review observed that, in respect of procurement, many overseas public authorities (including those in EU countries and so subject to the same regulations as the UK) faced the same challenges as the UK Government and chose to adopt similar responses. It noted that most of the government procuring agencies that were

[470] GRW/475 - [INQ000101273]
[471] GRW/476 - [INQ000092632]
[472] GRW/38 - [INQ000496743]

reviewed made extensive use of the equivalent of Regulation 32 in the 2015 Regulations in their own domestic regimes to make direct awards.[473]

GCF training programme

6.55. The GCF has a rolling 3-year Functional Plan with circa 10 improvement projects running across the function at any one time, resourced by people across the function. Because of these ongoing cross departmental activities, members of the GCO in particular, but also the wider GCF, are used to operating together as a combined commercial function, delivering more than the sum of their individual parts. This is demonstrated in the improved contract outcomes, improved retention and training levels, and year-on-year savings that the commercial function has been able to deliver.

6.56. One of the lessons learned before the pandemic but reinforced by it is that we need a fully staffed cadre of contract managers across all departments and authorities to manage the contracts let by the GCF. GCF continues to offer training to civil servants through its Contract Management Training Programme. There are three levels to this programme:

6.56.1. Foundation – which is an online 10 hour course followed by on line assessment.

6.56.2. Practitioner – a 6 month virtual cohort led program with expert training providing a deep understanding of how to maximise and protect value for government.

6.56.3. Expert – which builds on the Practitioner programme with the addition of a module focusing on strategy designed for those staff managing the most complex and strategic contracts across government.

6.57. The uptake on these courses continues to increase.

6.57.1. At the end of 2021 11,600 staff were accredited on the 'foundation' programme rising to 17,500 in 2022 / 2023. That number stands at 23,770 with a further 9,390 in training, as of March 2024.

6.57.2. At the end of 2021, 49 staff were accredited on the 'practitioner' programme rising to 111 for 2022 / 2023. For 2023 / 2024 that number stands at 270 with a further 900 in training, as of March 2024.

[473] GRW/477 - [INQ000477949]

6.57.3. At the end of 2021, 44 staff were accredited on the ‘expert’ programme rising to 83 in 2022 / 2023. For 2023 / 2024 that number stands at 130 with a further 460 in training, as of March 2024.

6.58. In addition to the Commercial and Contract management training programmes that were already in place (and continue to drive capability and assurance), the following 5 modules were released specifically to help with COVID-19.

6.58.1. Contract Management: Fundamentals for a Crisis Situation

6.58.2. Risk Management: On-boarding Suppliers or Contracts at Pace

6.58.3. Using Relationships & Contracts to Address Subcontractor & Market Concerns

6.58.4. Trade-offs when Varying Contracts

6.58.5. Contract Mobilisation: the Essentials in a Crisis

6.59. All five modules are still available through the Government Commercial College, the pan public sector commercial training hub which - as at January 2024 - 61,000 have registered for.

7. SECTION G: THE PROCUREMENT ACT 2023

7.1. The Procurement Act 2023, which received Royal Assent on 26 October 2023, was sponsored by the Cabinet Office and was introduced principally to take advantage of new opportunities presented by the UK's exit from the EU. In addition its provisions have been informed by lessons learned from the procurement challenges of the pandemic and seek to address those challenges in the event of a future pandemic.

7.2. The Ministerial foreword by Lord Agnew, then Minister of State for the Cabinet Office to the Transforming Public Procurement Green Paper published in December 2020, which set out the first proposals for the Procurement Bill, explained that: "COVID-19 has meant that, across the public sector, commercial teams have had to procure contracts with extreme urgency to secure the vital supplies required to protect frontline NHS workers, maintain public services and support our communities. I make no apology for that but there are lessons we can learn and the reforms in this Green Paper will strengthen our longstanding and essential principles in public procurement of transparency, ensuring value for money and fair treatment of suppliers."[474]

7.3. There are 3 specific changes in the 2023 Act which can, in part, be linked to the lessons learned from the Pandemic:

7.3.1. The greater flexibility in the types and nature of competitive procedures.

7.3.2. The additional ground to make direct awards when considered necessary to protect human, animal or plant life or health, or protect public order or safety, following regulations made by Ministers.

7.3.3. The greater obligations on authorities in respect of transparency and conflicts of interest.

7.4. I will now address each of these changes in turn.

Greater flexibility in the types and nature of competitive procedures

7.5. The first specific change in the 2023 Act which partly reflects the lessons learned from the pandemic (albeit it was an early proposal and likely would have been introduced even without the pandemic) is the introduction of greater flexibility in the nature of any competitive procedures.

[474] GRW/39 - [INQ000475569]

7.6. The 2015 Regulations set out extensive rules in relation to the design and conduct of competitive procurement processes. As I explained in Section C above, under the 2015 Regulations there are 5 competitive procurement options (open procedure, restricted procedure, competitive procedure with negotiation, competitive dialogue and innovation partnership), as well as the ability to make direct awards under Regulation 32.

7.7. The 2023 Act retains the open procedure (Section 20(2)(a)). However, the different alternative competitive procedures are removed. In their place, the 2023 Act allows greater flexibility in terms of an alternative approach by permitting an authority to carry out "such other competitive tendering procedure as the contracting authority considers appropriate for the purpose of awarding the public contract" (Section 20(2)(b)). This is referred to as the "competitive flexible procedure".

7.8. Sections 20(4) and 20(5) state that a competitive flexible procedure may (1) limit the number of participating suppliers, (2) provide for the refinement of award criteria, and (3) provide for the exclusion of suppliers if the conditions in Section 20(5) are met (for example with reference to an intermediate assessment of tenders). In short, the competitive flexible procedure will allow contracting authorities to design a procedure and build in suitable stages, such as delivering a prototype or product testing rather than following a prescriptive process.

7.9. 'Transforming Public Procurement: Government response to consultation', published in December 2021, explained that one of the intentions of the competitive flexible procedure was to drive greater innovation, which had been recognised as critical to the procurement conducted during the pandemic: "The competitive flexible procedure will drive greater innovation. Innovation proved critical to the Government's response to the Covid pandemic, for example, the Ventilator Challenge programme resulted in over 15,000 ventilators being delivered in just over four months by UK manufacturers who applied significant innovation to develop new solutions based on their expertise in other areas of manufacturing. The new procedure will be a mechanism for encouraging and accessing innovation to transform the delivery of public services."[475]

[475] GRW/40 - [INQ000471033]

Grounds to make, and safeguards in respect of, direct awards

7.10. As explained in Section B of this corporate statement, due to the urgent need for products and the short timescales in which supplies needed to be purchased, the early purchasing conducted during the pandemic was frequently not done through the normal formal procedures because they require a minimum time of 25 days between advertisement and the entering into of a contract, even before time is allowed for preparation of procurement documents and the evaluation of bids. Consequently direct awards were made under Regulation 32(2)(c) of the 2015 Regulations on the grounds of extreme urgency. This approach was in line with the guidance in PPN 01/20 (as explained in Section C of this corporate statement).

7.11. One of the specific lessons learned and changes made in the 2023 Act is the circumstances in which direct awards can be made. The ability to make a direct award in the case of urgency is retained in the 2023 Act. Section 41 permits a direct award where a direct award justification applies. The direct award justifications are set out in Schedule 5 and include 'urgency' at paragraphs 13 and 14:

> "13 Where—
>
> (a) the goods, services or works to be supplied under the public contract are strictly necessary for reasons of extreme and unavoidable urgency, and
>
> (b) as a result the public contract cannot be awarded on the basis of a competitive tendering procedure.
>
> 14 For the purpose of paragraph 13, urgency is unavoidable if it—
>
> (a) is not attributable to any act or omission of the contracting authority, and
>
> (b) could not have been foreseen by the contracting authority."

7.12. This provision is materially the same as Regulation 32(2)(c). However, the 2023 Act also grants a power for Ministers to make secondary legislation (i.e. regulations) at times of emergency which would allow contracts to be awarded as though a direct award justification applies. This power allows the regulations to stipulate the type of contracts which can be awarded without competition.

7.13. In particular, Section 42 of the 2023 Act provides that a Minister may, if he or she considers it necessary to "protect human, animal or plant life or health" or "protect public order or safety", by regulations provide that specified public contracts can be subject to a direct award. Regulations made under this power would, in accordance with Section 122, be subject to the 'made affirmative' procedure; this means that they will be effective immediately but must be approved by Parliament within 28 days or they will lapse at that point.

7.14. Any regulations made under Section 42 must also be kept under review by the Minister and revoked if the Minister considers that direct award is no longer necessary (Section 42(4)). The Explanatory Notes to the Procurement Act 2023 expressly link this power to future emergency events like the pandemic:[476]

7.14.1. "31. The legislation introduces new arrangements for how procurement should be conducted in an emergency such as the Covid-19 pandemic. There is a new power for Ministers to make provision in Regulations allowing the direct award of contracts when necessary to protect life so that contracting authorities can procure at pace."

7.14.2. "278. The purpose of this section [42] is to ensure procurements during an emergency event (like the Covid-19 pandemic) can be conducted as quickly and in full knowledge, even if the circumstances leading to the event are foreseeable (which would rule out the extreme urgency justification for direct award contained in paragraphs 13 and 14 of Schedule 5)."

7.15. 'Transforming Public Procurement: Government response to consultation' explained at paragraph 101 that part of the rationale for this new provision was that: "the Covid-19 situation exposed some uncertainty in applying Regulation 32 where the situation is prolonged or evolving."[477] In summary the following challenges were identified:

7.15.1. The difficulty of, and documentation and reporting burden on, contracting authorities in determining the application of Regulation 32, which had to be decided on a case-by-case basis, was a factor in seeking to change the circumstances in which direct awards can be made.

[476] GRW/478 - [INQ000471041]
[477] GRW/40 - [INQ000471033]

7.15.2. It became increasingly harder for contracting authorities to assess whether Regulation 32 was satisfied the longer the pandemic went on.

7.15.3. The potential uncertainty of the unforeseeability element of Regulation 32, given that there were indications that a pandemic may occur, but the nature, timing and scale was unknown.

7.16. A fuller explanation for the new powers in Section 42 was provided in the 'Memorandum from the Cabinet Office to the Delegated Powers and Regulatory Reform Committee' which identified the provisions of the Procurement Bill which conferred powers to make delegated legislation and explained why the power was granted. The Memorandum explained as follows in respect of the new ground of direct award:[478]

> "Context and Purpose
>
> 61. This clause confers a power to specify that certain public contracts (Including certain classes of public contracts) may be procured without running a competition, referred to as "direct award". Such a specification may only be made where the contracts are necessary either to protect human, animal or plant life or health or to protect public order or safety. The procurement of PPE during another pandemic might be one example of such circumstances.
>
> 62. Contracts within the scope of the statutory instrument would benefit from the provisions in clause 40 (direct award in special cases) which are the general provisions that permit 'direct award' in special cases. In other words, contracting authorities would be able to directly award public contracts identified in the statutory instrument (i.e. those contracts necessary to address the threat).
>
> Justification for taking the power
>
> 63. This power will exist to be able to deal more effectively with a situation akin to Covid-19. One of the difficulties encountered by contracting authorities during the Covid-19 pandemic was that limited tendering in emergency circumstances could only be used for circumstances that were unforeseeable or unattributable to the authority (see regulation 32(2)(c) of the Public Contracts Regulations 2015, similar provision to which is

[478] GRW/479 - [INQ000471045]

included in Bill). After a while the need for PPE was foreseeable, but there was still a rolling urgency to secure PPE supplies quickly and contracting authorities could not be certain that emergency provisions were applicable such that there was no breach of the existing regulations (i.e. due to the concern that the need for PPE is foreseeable at the time of contract placement and/or urgency exacerbated by a lack of planning to run a competition in time).

64. This power will ensure that contracts necessary to protect public health (and the other matters set out in the provision) can be placed during such events, even if the specific circumstance leading to the need for the individual contract is foreseeable or attributable to the contracting authority. It is only envisaged to be used for rare circumstances, where there is a need to 'overrule' these important caveats for use of 'extreme urgency' justifications in the new Bill.

65. Ministers may only make Regulations where they consider it "necessary" to provide for certain contracts to be awarded without competition (which is the effect of the limited tendering procedure - permitting contracts to be awarded absent competitive process). This approach does not allow contracting authorities to make decisions as to whether or not a specific contract is "necessary", but retains that decision with the Minister (albeit contracting authorities will need to determine whether their particular contract falls within the scope of the statutory instrument).

66. The power has also been limited in duration to the extent that subsection (4) requires that the Minister must keep the regulations under review and revoke them when they cease to be necessary (as defined in that provision).

Justification for the procedure

67. The Made Affirmative procedure allows the relevant statutory instrument to be effective immediately, but with a requirement that it must be affirmed by Parliament within a specified period (usually 28 days), otherwise it will lapse. It is necessary for the Regulations to come into force immediately as they are, by definition, necessary to deal with circumstances requiring an immediate response and this will avoid any

delay in placing contracts. It does, though, make provision for Parliamentary oversight of the propriety of the Regulations and we consider this to be a suitable balance between constitutional propriety in the process of making Regulations and addressing urgent and potentially life-threatening circumstances."

Greater obligations on authorities in respect of transparency and conflict of interests

7.17. The 2023 Act introduces greater safeguards to protect against fraud and conflict of interests, including in cases of direct awards.

7.18. The first safeguard is the introduction of additional transparency under the 2023 Act. Section 44 requires that before any direct award is made a contracting authority must issue a transparency notice stating that it intends to do so.

7.19. Under the 2015 Regulations, there is no obligation to issue such a notice, instead such a notice is voluntary. The current rationale for an authority doing so is that a voluntary transparency notice is a potential defence to a claim for a declaration of ineffectiveness (Regulation 99). However, as the Minister of State at the Cabinet Office (Baroness Neville-Rolfe) recognised in the debates in the House of Lords on the Procurement Bill, the publishing of transparency notices "obviously did not happen during Covid and [the introduction of mandatory transparency notices] is a major safeguard."[479]

7.20. The change to a mandatory transparency notice is in keeping with the increased transparency provisions more generally in the 2023 Act which will require information to be published throughout the commercial lifecycle, making it easier for anyone to monitor procurement decision making. The general increase in transparency is, as explained at section 4.10 of the Research Briefing on the Procurement Bill published on 5 January 2023 partly "in response to lessons learned during the Covid-19 pandemic".[480]

7.21. The development of the new Central Digital Platform will digitise the process for notice publication and save time for contracting authorities. Publication of these notices on the Central Digital Platform (as mandated under the Act) will ensure the information is publically available, providing a public record of UK public procurement and make scrutiny of direct award decisions easier.

[479] GRW/480 - [INQ000471034]
[480] GRW/481 - [INQ000471046]

7.22. Contracting authorities will need to provide information about which of the grounds for the direct award, as set out in the Procurement Act 2023, are relied on, and provide justification for their reliance on those grounds.

7.23. If the intended supplier is known at the time of publication, the notice must include details. The Procurement Act 2023 (Section 41) allows a contract to be awarded to a supplier which is an excluded supplier; that is to say, a supplier to whom a public contract could not otherwise be awarded because they meet any of the exclusion criteria in the Act. This can only be done where the contracting authority considers that there is an overriding public interest in doing so, and the Act sets out the circumstances in which such an overriding public interest exists. Examples include where awarding the contract to the supplier in question is necessary in order to construct, maintain or operate critical national infrastructure, or to ensure the proper functioning of a sector on which the defence, security or economic stability of the UK relies. As such, the transparency notice must indicate whether the supplier is an excluded supplier, and if so which exclusion ground applies and how the overriding public interest arises.

7.24. When making a direct award under regulations made pursuant to section 42 of the Procurement Act 2023, which allows for direct award where Ministers have determined that direct award is necessary in order to protect life, health, public order or safety, contracting authorities also need to include in the transparency notice the title and registration number of the statutory instrument containing those regulations.

7.25. The Act allows contracting authorities to make a direct award following a competitive procurement in which it has received no suitable bids and considers that it cannot make an award following that procedure. Where this is the case, the contracting authority must include in the transparency notice an explanation of why there were no suitable tenders or requests in response and why it considers that competitive award is not possible in the circumstances.

7.26. In addition to ensuring contracting authorities provide justification for their reliance on grounds permitting the direct award of a contract, the transparency notice includes information about the contract itself, including its subject-matter, estimated value, the estimated date on which it will be entered into and whether it is a framework or a special regime contract.

7.27. Contracting authorities may also include any known risks which could jeopardise the satisfactory performance of the contract but cannot be addressed in the contract as

awarded, meaning that it may require subsequent modification. Inclusion of this information in the transparency notice allows for such a modification to be made at a later point.

7.28. The second safeguard is the greater obligations on authorities in respect of conflicts of interest.

7.29. Regulation 24 of the 2015 Regulations currently requires contracting authorities to "take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement procedures".

7.30. One of the lessons learned from the procurement in the pandemic was the challenge of managing conflicts of interest during an emergency, as set out in the Boardman Review and NAO Reports in 2020. In response, PPN 04/21 was issued to set out further guidance to assist contracting authorities to develop and enhance local strategies, systems, processes and procedures to prevent, identify and remedy conflicts of interest. The updated policy approach requires central government contracting authorities to have an internal framework in place to identify, prevent and manage conflicts of interests. I address PPN 04/21 in more detail in Section C of this corporate statement.

7.31. The 2023 Act went on to enshrine these lessons learned in legislation by increasing the obligations on authorities in respect of conflicts of interest. The changes made in respect of conflicts of interest in Part 5 of the Act are as follows:

7.31.1. First, under Sections 81 and 82, the general obligation on authorities is now to "take all reasonable steps" to (1) identify, (2) keep under review, and (3) mitigate any conflicts of interest to ensure that it does not put a supplier at an unfair advantage or disadvantage.

7.31.2. Second, Section 81 details the individuals in respect of whom conflicts, or potential conflicts, should be identified. The scope of individuals is greater than the 2015 Regulations and not only includes people acting for the contracting authority in relation to the procurement (Section 81(2)(a)); but also a person with influence on a decision made by the contracting authority (Section 81(3)), and a Minister acting in relation to the procurement (Section 81(2)(b)).

7.31.3. Third, Section 83 introduces a new requirement for a contracting authority to prepare a specific conflicts assessment in relation to each

procurement before publishing a tender or a transparency notice and then to keep the conflicts assessment under review, revising it as necessary. This obligation will therefore still apply in the case of a direct award under Section 41.

7.32. The conflicts assessment must include details of:

7.32.1. Any conflicts of interest or potential conflicts identified in accordance with Section 81.

7.32.2. Any steps an authority has taken or will take for the purposes of its Section 82 duty to mitigate.

7.32.3. Any steps an authority has taken or will take to demonstrate that no conflict or potential conflict exists where it is "aware of circumstances that it considers are likely to cause a reasonable person to wrongly believe there to be a conflict or potential conflict of interest."[481]

7.33. Sections 82(3) and (4) state that if a conflict of interest puts a supplier at an unfair advantage, and if steps to mitigate cannot avoid that advantage, the supplier must be excluded from the procurement. There was no direct equivalent provision in the 2015 Regulations. The 2015 Regulations include a discretionary exclusion ground in regulation 57(8) where the conflict cannot be effectively remedied. However the 2023 Act, as shown above, includes a mandatory requirement that the contracting authority "must" exclude a supplier in this scenario.

7.34. The Minister of State at the Cabinet Office (Baroness Neville-Rolfe) explained in the debates in the House of Lords on the Procurement Bill that by these sections of the 2023 Act on conflicts of interest "the Government have sought to give greater clarity on these obligations, partly in the light of the difficult experience during Covid-19"[482].

7.35. The Minister further explained that these measures were to address the recommendations of the Boardman Review and NAO Reports: "One point worth making is that a key theme in Boardman and the NAO reports mentioned was the lack of record-keeping and audit around decision-making. The Procurement Bill strengthens the requirements on conflicts of interest compared with the current law.

[481] Section 83(4) retains the obligations to manage perceived conflicts of interest in regulation 24 of the Public Contracts Regulations 2015. The purpose of this provision is to help contracting authorities ensure that their procurements are protected as much as possible from bias and also apparent bias, both of which are possible grounds for a public law challenge.
[482] GRW/480 - [INQ000471034]

A new duty has been introduced in Clause 78(5)[483] to require contracting authorities to confirm that a "conflicts assessment" has been prepared and then reviewed and revised as necessary when publishing a procurement note."[484]

[483] This became Section 83(5) in the final Procurement Act 2023: "*A contracting authority must– … (c) when publishing any relevant notice, confirm that a conflicts assessment has been prepared and revised in accordance with this section.*"
[484] GRW/482 - [INQ000471042]

8. SECTION H: CONCLUDING REMARKS

8.1. The scale of the challenge that the pandemic posed was unique in peacetime. The scope and intensity of procurement activity that was undertaken across government to meet this challenge was therefore substantial and underpinned our ability as a country to combat the virus, to allow the NHS to continue to function, and ultimately, to protect the public.

8.2. Outside of the uncertainties of a pandemic we would try to buy only what was going to be used; during the pandemic we were asked to buy more than it was hoped we would actually need. As I said in the Ventilator Challenge Scrapbook: "It is a contrary kind of triumph to work so hard to build products that you hope will never be needed, but even then we will have built an enormously valuable insurance policy that leaves our country infinitely better prepared to face whatever twists and turns Covid throws at us in the months to come."[485] The same applies to the volumes of PPE and other goods and services we were asked to acquire.

8.3. We welcome the opportunity provided by this module of the Inquiry to ensure we learn the lessons from what and how and how much we procured for this pandemic, in order to be as ready as possible for the future crises that we will inevitably face. The considerable work undertaken under great pressure, and the skill demonstrated by the civil servants across the GCF and beyond, that is outlined in this statement, will I hope be recognised. However, it is a key part of the GCF culture to continuously improve, so as ever the Government will seek ways to learn, and improve.

8.4. The Cabinet Office has of course already sought to learn lessons and identify opportunities for improvement throughout the pandemic, as is made clear by the reviews detailed in this statement. The Inquiry will of course consider these in detail and reach its own conclusions.

8.5. We will, as always, support the Inquiry in this endeavour. As this statement shows, the procurement story during the pandemic was complex and against the backdrop of a highly uncertain environment and unprecedented market conditions. I have sought throughout this first Cabinet Office corporate statement in this Module to provide as much clarity as possible on who did what and when, but understand that this will raise further questions to be addressed by future statements that the Cabinet Office will provide for this Module. As is made clear at the beginning, more

[485] GRW/215 - [INQ000513008]

procurement activity was undertaken than has been requested is covered in this statement. The Cabinet Office would be happy to provide such further information as the Inquiry would find helpful.

8.6. I would also encourage the Inquiry to revert with any queries they may have about the operation of the procurement function. While the functional model of working ensured that the GCF was able to respond to challenging commercial demands during the pandemic, the way of working is different to other areas of government that the Inquiry has investigated to date.

8.7. While existing legal flexibilities were used to secure value for money as quickly as possible throughout the pandemic, Section G of the statement explains how the Procurement Act 2023 has substantially re-written the procurement regulations – to provide greater flexibility to make direct awards when considered necessary, and introduce greater obligations on authorities in respect of transparency and conflicts of interest. I would encourage the Inquiry to take this into account when considering its recommendations.

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: 5 July 2024