Witness Name: Dame Emily Lawson
Statement No: 3
Exhibits: [EL3/001] – [EL3/087]
Dated: 7 February 2025

UK COVID-19 INQUIRY

MODULE 5

THIRD WITNESS STATEMENT OF DAME EMILY LAWSON

I, Dame Emily Lawson PhD, of NHS England (Wellington House, 133-135 Waterloo Road, London, SE1 8UG), will say as follows:

Section 1 - Introduction

1. I am the Chief Operating Officer (Interim) ("**COO**") of NHS England, a post I have held since 1 November 2023. I am also an executive member of the Board of NHS England.

2. This is my third witness statement to the Inquiry. My first witness statement related to my role within the Covid-19 vaccination programme and was requested under Module 4. My second witness statement was requested under Module 5 and related to my role within the procurement programme for ventilators and PPE, but specifically in connection with the high priority lane.

3. I make this third witness statement in response to the UK Covid-19 Inquiry's Rule 9 request for evidence dated 30 August 2024 under Module 5 of the Inquiry ("**the Second Module 5 Rule 9 Request**"), which examines a range of issues relating to public procurement of key equipment and supplies across the UK public sector in relation to the Covid-19 pandemic and the onwards distribution of the key equipment and supplies. I understand that the Second Module 5 Rule 9 Request focuses on the period of time between 1 January 2020 and 28 June 2022 ("**Relevant Period**").

4. As set out more fully below, and in my previous statements, in the last seven years I have principally worked at NHS England and No10 Downing Street, starting in NHS England in November 2017 before moving to No10 in July 2021. I briefly returned to my role in NHS England to lead the vaccine programme again in October 2021 until March 2022 when I returned to the No10 role.

5. This Statement aims to respond to topics and questions set out in the Second Module 5 Rule 9 Request, without seeking to duplicate the extensive factual material provided to the Inquiry in the First Witness Statement of Julian Kelly. I have repeated some of the contents of my second witness statement as the scope of the Second Module 5 Rule 9 Request overlaps with, and asks more detailed questions on, several matters covered in that statement. In certain places within this Statement, I have also referred to parts of my second witness statement. As suggested by the Inquiry, this Statement adopts its own structure whilst aiming to answer the Inquiry's requests for information comprehensively.

6. I note that the Second Module 5 Rule 9 Request states that the term "key healthcare equipment and supplies" includes PPE, ventilators and oxygen, lateral flow tests and

PCR tests. It also indicates that where questions asked of me refer to key healthcare equipment and supplies, this should be read as including PPE, ventilators and oxygen, lateral flow tests and PCR tests.

7. This Statement has the following sections:

   a. Section 1: Introduction;

   b. Section 2: Background, previous experience and roles;

   c. Section 3: Summary of relevant roles during the pandemic;

   d. Section 4: Governance and working with others;

   e. Section 5: Procurement structures, systems and processes;

   f. Section 6: Award and value of contracts;

   g. Section 7: Compliance and regulation of contracts; and

   h. Section 8: Reflections.

8. In this Statement I have referred to NHS England, the Department of Health and Social Care ("**DHSC**") and the Secretary of State for Health and Social Care ("**SSHSC**") in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require.

9. NHS Trusts and NHS Foundation Trusts are referred to collectively as "**Trusts**" in this Statement unless otherwise stated.

Section 2 - Background, previous experience and roles

10. I have been asked to set out the positions which I held immediately prior to the pandemic and during the pandemic. My background, experience and roles are set out in my first and second witness statements, but for ease of reference I have repeated that information below.

11. I first set out my relevant background and experience prior to that period as context to my role as Chief Commercial Officer ("**CCO**") of NHS England.

12. I obtained an undergraduate degree in Natural Sciences (Genetics) from the University of Cambridge, followed by a PhD in molecular genetics from the John Innes Institute (University of East Anglia). I then did postdoctoral research at the University of Pennsylvania in genetics. I left academia to join a biotechnology company called Avitech Diagnostics in Malvern, Pennsylvania, as Manager of Business Development.

13. I then joined the management consultancy firm McKinsey and Company in London, where I worked from November 1998 to September 2013. I specialised over time in supporting organisations to make long term, sustainable improvements in performance, including leadership roles in the Human Capital part of McKinsey's organisation practice. I also led the Women Matter research and publication from 2010 to 2012. I served clients in multiple industries including health, pharmaceuticals, telecoms, banking, and manufacturing. I conducted one piece of work for the NHS over that period.

14. From September 2013 to May 2015, I was the HR Director at Morrisons plc, a UK supermarket chain with a manufacturing and distribution business. From September 2015 to September 2016, I was Chief People Officer at Kingfisher plc, an international retailer.

15. From 1 November 2017 to 1 April 2020, I was employed by NHS England, initially as National Director for Transformation and Corporate Operations ("**ND TCO**"). During this period, from 11 December 2018 I held the same position on the senior leadership team for the joint NHS England and NHS Improvement organisation. My responsibilities were for the internal functions of first NHS England and then the joint organisation (HR, IT, Estates), for the improvement functions of NHS England and for the primary care support services contract. As part of this set of responsibilities, I led the design and integration process for NHS England and NHS Improvement from 11 December 2018 to 1 July 2019.

16. Formally from 1 April 2020 to 16 July 2021, I was CCO of NHS England and NHS Improvement. I had stepped up previously to support the commercial function as acting head from 1 July 2019, when there was no one in the newly created role due to the reorganisation of NHS England and NHS Improvement. A recruitment campaign did not identify the right candidate and my background in the private sector meant I had relevant skills. My responsibilities as CCO were for procurement, estates, innovation, and other key commercial functions across the health service.

17. Almost immediately on formal appointment as CCO, however, I became involved with the Covid-19 response, focusing on ensuring supply and distribution of ventilators and shortly after, personal protective equipment ("**PPE**"), working integrally with the DHSC and others. I was formally seconded to DHSC from 20 March 2020 to 9 November 2020 **[EL3/001 INQ000497445]** to ensure that the demand, supply, allocation and storage of PPE, ventilators and oxygen and non-clinical goods and services was effectively managed throughout the pandemic. As I say later in this Statement, this became more than a full time set of responsibilities. It was during my time in this part of the Covid-19 response that I worked with the 101 Logistics Battalion ("**101 Log**") and with external contractors with experience of supply chain and logistics, and further developed the familiarity I had developed in this area in the private sector.

18. Through and in addition to my roles with NHS England, from July 2019 to July 2021, I was a non-executive director of Supply Chain Coordination Limited ("**SCCL**"), a company set up in 2018 and owned by DHSC to manage the business known as NHS Supply Chain. This business sources, delivers and supplies healthcare products, services and food to providers of NHS service across England. In 2018, DHSC announced that it intended to transfer SCCL to NHS England and Improvement. I, and the then Director of M&A and New Organisational Models at NHS Improvement (now NHS England), joined the SCCL board to help plan for the proposed transfer. After a delay due to the pandemic, ownership of SCCL transferred from DHSC to NHS England on 1 October 2021. For the majority of the Relevant Period, SCCL remained under control of DHSC.

19. From 9 November 2020 to 16 July 2021, I was National Director for Covid Vaccine deployment at NHS England. This period covered the initial roll-out and subsequent expansion of the deployment of the Covid vaccines. During this time I also maintained some responsibilities for the CCO role, but I was no longer involved in the PPE function other than as an advisor on request, as the vaccine senior responsible officer ("**SRO**") role required full time attention.

20. From 19 July 2021 to 22 October 2021, I was Head of the Prime Minister's Delivery Unit, a role that the Cabinet Secretary and Prime Minister ("**PM**") Boris Johnson created and requested that I take up. I was on secondment in this role. My responsibilities were to establish the unit, hire people into roles, establish relationships across government, develop delivery intellectual property, processes, skills, and tools, and thereby support delivery of programmes related to the PM's top five missions.

21. From 25 October 2021 to 31 March 2022, I returned to NHS England once again as National Director for Covid vaccine deployment. My responsibilities were to ensure the winter booster campaign for Covid vaccination, and the seasonal flu programme, were successful.

22. I rejoined No10 in April 2022 and continued until 1 September 2023. Until 24 January 2023, my title was Head of the Prime Minister's Delivery Unit at No10 Downing Street. I had responsibility both for the Delivery Unit and for the No10 Data Science team. I acted full time in that role by the Cabinet Office, on secondment from my substantive employment at NHS England. On 25 January 2023, the Delivery Group was created across No10 and the Cabinet Office. The Delivery Group consisted of the No10 Delivery Unit, the No10 Data Science team, the Cabinet Office Evaluation Taskforce, the i.AI unit, the Cabinet Office Delivery architecture team, and the Cabinet Office Government Strategic Management Office.

23. In terms of experience and skills relevant to the topics covered in this Statement, I gained extensive process design and improvement experience from my time with McKinsey. I was part of the McKinsey team that put forward the life sciences strategy for Gordon Brown. I also have experience in identifying and removing inefficiencies from manufacturing processes, retail and sign up process.

24. I led the integration of NHS England and NHS Improvement, which combined processes and created integrated approvals and governance processes.

25. In terms of supply chain management, I was CCO of NHS England at the time and had worked in a senior manager role within Morrisons, a large focus of which is maintaining an effective supply chain.

Section 3 – Summary of relevant roles during the pandemic

26. This Section 3 sets out a high level summary of my roles in relation to key healthcare equipment and supplies during the Relevant Period and the dates I was involved.

Lateral flow tests and PCR tests

27. I was not involved in the procurement of lateral flow tests or PCR testing equipment. I was not involved in Operation Moonshot. In late March 2020, as a result of my involvement with PPE, I took part in conversations on the viability of sourcing swabs used in lateral flow tests as part of PPE. As swabs are not typically considered PPE, this was not considered viable and I was not involved any further.

28. The Statement focuses on the two areas of procurement of key healthcare equipment and supplies with which I was involved – ventilators/oxygen and PPE. I set out below high level summaries of my roles relating to each. A more detailed chronological explanation of the activity I undertook is set out in Section 5 of this Statement.

Ventilators/oxygen

29. NHS England declared a Level 4 emergency on 30 January 2020. It began developing planning scenarios in relation to NHS capacity based on modelling of the spread of Covid-19 developed by the Scientific Advisory Group for Emergencies ("**SAGE**"), including the extent of the need for hospital beds that could provide ventilation to patients.

30. The modelling indicated that the number of ventilated beds would exceed supply. A programme of work was undertaken to obtain ventilators for use in hospitals. DHSC was responsible for procuring ventilators for the NHS and NHS England was responsible for allocating ventilators within the NHS once they had arrived into the country.

31. I became involved in the ventilator procurement programme on 5 March 2020 following an action taken from that day's National Incident Response Board ("**NIRB**") meeting, and began working closely with individuals in the DHSC ventilator procurement team.

32. I was appointed SRO of the programme. I provided recommendations to senior DHSC managers on offers to supply ventilators to the NHS. My role was to provide executive level connection between the DHSC team and the NHS.

33. From 13 March 2020, the Cabinet Office ran the Ventilator Challenge which involved companies within the UK developing and manufacturing ventilators to supply to the

NHS. I was not directly involved in the Ventilator Challenge after its launch. Although I was invited to meetings, it was led elsewhere and I rarely attended. Instead, I kept up to date with its progress through written reporting and occasional conversations, as newly built ventilators coming out of the Ventilator Challenge were an additional supply source and helped feed into decisions on whether to buy from elsewhere.

34. Many hospitals, healthcare systems and countries around the world were also seeking to buy ventilators at that time. The competition for available supplies was incredible. A decision often needed to be made in hours to secure a deal, which meant the team carrying out the relevant clinical, financial and commercial assurance checks worked at extreme pace and often around the clock.

35. During May and June 2020, it became increasingly clear that the number of existing ventilators, coupled with those being produced via the Ventilator Challenge and those procured by DHSC, meant there would be enough ventilators to reach the Government's target of 30,000. The extent of activity required for ventilator procurement, particularly sourcing from overseas suppliers, reduced accordingly.

36. I became SRO of the Covid-19 vaccination deployment programme on 9 November 2020 and my involvement in the ventilator programme ceased from that date.

PPE

37. Prior to the pandemic, PPE was procured directly by Trusts predominantly through NHS Supply Chain, run by SCCL. Through February and March 2020, the demand for PPE from Trusts grew significantly day on day. It soon exhausted the ability of NHS Supply Chain to meet all orders from existing suppliers. PPE from a Government stockpile was gradually released to Trusts, but this did not meet demand. DHSC took on responsibility for procuring and distributing PPE supplies from new suppliers.

38. I became involved in the PPE programme from 10 March 2020, when NHS England's Chief Executive asked me to investigate claims that Trusts were not receiving their orders of PPE from NHS Supply Chain.

39. I was appointed SRO of the programme. I provided recommendations to senior DHSC officials on offers to supply PPE to the NHS. This included consideration of whether an offer was likely to provide the types of PPE needed by Trusts and other NHS service providers, bearing in mind demand levels, existing stock and expected delivery timescales.

40. As with ventilators, the worldwide demand for PPE at the time was intense. China was the main manufacturing hub for PPE and we relied heavily on the British Embassy in Beijing to identify new suppliers and manufacturers. Contracts had to be arranged quickly or the PPE would be lost to competing buyers from across the globe. Within extremely compressed timescales, the PPE team needed to consider, identify or follow-up offers and opportunities, carry out technical, financial and contractual due diligence, make a decision whether to buy and arrange payment and delivery. The team worked tirelessly to ensure enough PPE was available to meet the demands of the NHS.

41. My involvement in PPE ceased when I became SRO of the Covid-19 vaccination deployment programme on 9 November 2020.

Section 4 – Governance and working with others

42. This Section 4 sets out the overarching governance arrangements that spanned the ventilator and PPE programmes. I then explain, across both programmes, the Government departments and national bodies with which I worked, the most significant management consultants that assisted and the extent of engagement with industry.

Overarching governance

43. DHSC established its battle plan in response to Covid-19 in March 2020 with six key workstreams:

    a. resilience for the NHS and adult social care;

    b. supply of key products and equipment;

    c. testing;

    d. technology accelerating new interventions;

    e. social distancing; and

    f. shielding.

44. There were four sub-categories within the supply of key products and equipment workstream (which subsequently became the supply and distribution of key products):

    a. PPE;

    b. medicines;

    c. tests; and

    d. oxygen & ventilation and medical devices & clinical consumables.

45. The PPE sub-category was often referred to as the PPE Cell. I was appointed SRO of the PPE Cell jointly with the DHSC SRO (Jonathan Marron, appointed in the last week of March 2020). I was also the SRO for the oxygen & ventilation and medical devices & clinical consumables sub-category.

46. For both roles, I operated under the terms of the secondment agreement entered into between NHS England and DHSC, which included regular reporting into the Cabinet Office and No.10.

47. Individuals from DHSC and NHS England (and other bodies, such as Cabinet Office) worked together within these cells and are examples of "aligned cells". Paragraphs 32

to 34 of Annex 3 of the First Witness Statement of Julian Kelly provides additional explanation of the aligned cells from an organisational perspective.

Government departments

48. DHSC made the final decisions on procurement of ventilators and PPE. As SRO of both programmes (albeit joint with Jonathan Marron on PPE), and as I was acting under secondment to DHSC, I worked extremely closely with DHSC throughout this period. I expand on this further in Section 5 of this Statement, but I was essentially part of the DHSC team albeit with responsibility for bringing the NHS demand signal for ventilators and PPE to their attention. In respect of the people I worked alongside, there are too many to name individually, but on ventilators Chris Stirling was a key figure who had led the DHSC task and finish group tasked with procuring oxygen, oxygen concentrators and ventilators since the start of March 2020. Chris was acting under Steve Oldfield, DHSC's Chief Commercial Officer, with whom I liaised extensively on PPE supply issues both before and after Jonathan Marron joined the team.

49. I had regular interaction with the then PM, Boris Johnson, on both ventilators and PPE. In the late March and early April 2020 period, as demand for ventilators was projected to exceed supply, I regularly joined the PM's daily 9:15am C-19 Strategy Meetings, alongside DHSC colleagues, to discuss the NHS demand signal against the domestic and overseas ventilator supply position. I provide an example of the actions relating to ventilators, several of which fell to me, from the C-19 Strategy Meeting on 30 March 2020 **[EL3/002 INQ000541367]**.

50. The rising demand for PPE during March and into April and May 2020 resulted in me attending the C-19 Strategy Meetings to discuss demand and supply of specific types of PPE, using modelling to indicate the extent supply was projected to meet demand based on delivery schedules and how additional ordering changed the picture. I provide the paper prepared for the 4 May 2020 C-19 Strategy Meeting which took a deep-dive into the PPE situation **[EL3/003 INQ000541369]**.

51. China was a main focus for sourcing overseas supply of ventilators and PPE. I worked closely with Barbara Woodward, British Ambassador to China, and her team in the Foreign, Commonwealth and Development Office ("**FCDO**") that were based in China. Barbara and her team were invaluable in identifying suppliers/manufacturers, carrying out due diligence, facilitating offers and deals from China-based parties and assisting on the logistics of delivery, including getting equipment loaded onto planes bound for the UK. I provide an email chain from 10 April 2020 that starts with an email from

Barbara asking certain questions with a view to getting ahead of the curve in respect of procurement of medical supplies from China **[EL3/004 INQ000541353]**. This email chain indicates the breadth and depth of support the ventilator and PPE teams were receiving from the FCDO team in China. From 7 April 2020, I received the daily China Network Covid Procurement Update from Barbara **[EL3/005 INQ000541350]**, which summarised for ventilators and PPE; the details of credible offers, new contracts signed overnight, that day's (and the next day's) flights leaving China, a list of type and amounts of equipment on board those flights, arrival times in the UK and any high-level discussions with Chinese Government figures.

52. The FCDO also provided support beyond China. For example, the 4 April 2020 daily Joint Cross-HMG Medical Supplies Sitrep **[EL3/006 INQ000541345]**, which I received and which was produced by the Joint Assistance Co-ordination Team ("**JACT**") with input from DHSC, FCDO and Department of International Trade ("**DIT**"), indicates that JACT was investigating possible new leads for ventilators in Taiwan, France, Sweden, Kuwait, Qatar and Germany.

53. I worked with the British Embassy in Paris to get the transport of a consignment of hand sanitiser unblocked, as it had been stopped due to French legislation on restrictions of the transport of alcohol gel across borders. I provide an email chain from 18 March 2020 which explains the background to the issue **[EL3/007 INQ000541337]**.

54. The FCDO also asked for my assistance on communications with other countries. For example, on 16 April 2020 I spoke with Judith Gough, the Ambassador to Sweden, on the potential for the UK and Sweden to share experience and ensure we were learning from different experiences **[EL3/008 INQ000541356]**. At the same time, a decision had been made not to share PPE with Sweden, but this did not rule out future sharing options.

55. On 27 March 2020, I met with Antonia Romeo, now Permanent Secretary at the Ministry of Justice ("**MOJ**"), but prior to January 2021 Permanent Secretary at DIT. Her team were part of the JACT and supported purchasing across various countries. Antonia put me in touch with Harjinder Kang, DIT's Director of Healthcare, Life Sciences and Bio Economy, who joined the daily PPE calls. From my perspective, the DIT team and the FCDO team worked seamlessly to provide the overseas intelligence and support needed to procure the equipment we needed. I kept in contact with Antonia, inviting her on 24 April 2020 to join the daily PPE calls and to come into Skipton House, NHS England's London offices, where various teams associated with the PPE supply chain were located **[EL3/009 INQ000541361]**.

56. On PPE, I worked very closely with a team from the Cabinet Office, particularly Gareth Rhys-Williams, then Chief Commercial Officer for the Civil Service, and Andy Wood who led the Cabinet Office's Complex Transactions Team. The Cabinet Office supported the DHSC teams with procurement. Alongside DHSC and NHS England, I provided input to the Cabinet Office's comprehensive PPE Sourcing Strategy, an updated version of which was circulated to me on 29 May 2020 **[EL3/010 INQ000541364] [EL3/011 INQ000541365]**.

57. On ventilators, the Cabinet Office, DIT and the Department for Business, Energy and Industrial Strategy ("**BEIS**"), as it was then, were all heavily involved with the Ventilator Challenge. Although my involvement on the Ventilator Challenge was limited, I did receive regular reports as numbers of domestically made ventilators fed into decisions on the extent non-domestic purchasing was necessary.

58. I did not liaise directly with BEIS, although I spoke with Alok Sharma, Secretary of State at the time for BEIS, on 2 April 2020 **[EL3/012 INQ000541344]** on additional connections and support for the "make" team (i.e. the DHSC-led team that were supporting the domestic production of PPE) and the "buy" team, given BEIS's network of businesses.

59. I also attended a number of calls and meetings with Michael Gove, then Chancellor of the Duchy of Lancaster ("**CDL**"). The first call I attended was on 14 March 2020 which brought together Michael Gove, Lord Agnew, Penny Mordaunt the then Paymaster General, Steve Oldfield from DHSC, Gareth Rhys Williams from the Cabinet Office, as well as a number of other people. The call was to discuss how the Cabinet Office could help DHSC to ensure that everything possible was done to lead the effort to ensure equipment was sourced in the most effect way possible **[EL3/013 INQ000541335] [EL3/014 INQ000541336]**. There were a number of follow-up calls and meetings to discuss resulting actions.

60. I did not liaise directly with the Ministry of Housing, Communities and Local Government ("**MHCLG**") on PPE but, on a local authority level, a representative from NHSE working within the PPE team attended calls with the chairs of the local resilience forums ("**LRF**") from 1 April 2020. In a couple of instances, I engaged directly with LRF leads myself; I found these contacts very helpful for my own understanding of the situations they were dealing with locally.

61. Barry Hooper, Chief Commercial Officer at the MOJ, took on the role of Programme Director for the aligned cell on 31 March 2020. Barry had a wide remit, including ensuring robust governance structures were in place for the programmes and

considering process flows. I provide an example of his input on 15 April 2020 on procurement and buying options for PPE **[EL3/015 INQ000541355]**.

62. As set out in Section 5 of this Statement, support and assistance was provided by the military on PPE logistics, supply and distribution. The assistance was from 101 Logistics Brigade, led by Brigadier Prosser. Representatives from the military attended a number of the calls, including the daily PPE procurement and allocation calls.

63. I also liaised extensively with Lord Deighton who, from 18 April 2020, led the national efforts to obtain PPE and was advisor on PPE to the SSHSC. One example of how we worked together relates to discussions I had to potentially set up a textile manufacturing facility in the North East of England to produce PPE. I shared thoughts with Lord Deighton on 24 April 2020 and he offered to be part of a roundtable meeting, partially to combat concerns that we were seen as "faceless bureaucracy" **[EL3/016 INQ000541362]**. Lord Deighton also routinely forwarded to me offers or referrals for PPE that he had received to feed into the PPE Cell's process for considering offers. I provide two referrals he received and passed to me on 19 April 2020 from Robert Peston, ITV's political editor **[EL3/017 INQ000541359] [EL3/018 INQ000541360]**.

National bodies

64. In the UK, the technical specifications for all protective equipment are overseen by the Health and Safety Executive ("**HSE**") in the case of equipment meant to protect the provider of services (including healthcare), and the Medicines and Healthcare products Regulatory Agency ("**MHRA**") where the items fall into the definition of a medical device. MHRA regulation also oversees supply chain security for the relevant items.

65. These bodies supported the national effort more generally, for example, by being involved in assessing the fitness for purpose of items of PPE entering the country and ensuring compliance with regulatory requirements, as well as overseeing the specifications developed for the Ventilator Challenge. MHRA and HSE were also a core part of our work to identify whether reusable PPE would be part of the solution to our supply challenges.

66. MHRA was also closely involved in the specifications drawn-up for domestically produced ventilators for the Ventilator Challenge.

67. I liaised with Dame June Raine, Chief Executive Officer at MHRA, who I knew from a senior women's networking event we had both previously attended. We agreed ways of working that would enable the PPE Cell to raise points at issue with MHRA at speed **[EL3/019 INQ000541339] [EL3/020 INQ000541349]**

68. There were, at times, daily calls that included HSE and MHRA representatives, to work through technical problems.

69. An example of working with MHRA and HSE was on the potential to extend the life of PPE. We worked with MHRA and HSE on what was needed to certify expired PPE as clean and reusable and how to reuse "used" PPE **[EL3/021 INQ000541352] [EL3/022 INQ000541354] [EL3/023 INQ000541358]**. MHRA had a process through which they re-examine equipment to determine if its "use by" date can be extended. Certain FFP3 masks were found to be beyond their stated expiry date, but were re-examined and declared fit for use.

70. NHS England oversaw the ventilator distribution process. I worked with a large number of people from NHS England who were either members of the ventilator programme, the distribution process or senior NHS England individuals with whom I would discuss matters. These included Lord Stevens (as he is now), Preeya Bailie, Keith Willett, Pauline Phillips and Ramani Moonesinghe. Ramani was the clinical lead on the ventilation cell. There were also NHS England individuals assisting on the PPE side.

71. In relation to SCCL, I was a non-executive director during the early phase of the pandemic, which facilitated access to senior managers within SCCL to discuss equipment supply. While I had extensive discussions with SCCL on PPE, which are set out in more detail in Section 5 of this Statement, I had relatively limited interaction on ventilators. SCCL already had commercial arrangements with a range of ventilator suppliers and worked with them on purchasing any excess stock for use within the NHS.

72. On PPE, I liaised closely with the Chair of SCCL, Jim Spittle, and the SCCL Chief Executive Officer, Jin Sahota. Representatives from SCCL attended the daily project management calls alongside representatives from DHSC, NHS England, and Cabinet Office.

Devolved administrations

73. England's Chief Medical Officer, Chris Whitty, had regular meetings with Chief Medical Officers in the devolved administrations. England's Chief Nursing Officer, Ruth May, was also meeting with her counterparts. This facilitated discussions with the devolved administrations on PPE. A system of mutual aid was discussed and actioned for supplies. For example, in early April 2020, England had a shortage of gowns but was aware that Northern Ireland had an excess in stock. On 4 April 2020, Jonathan Marron liaised with the Northern Ireland PPE supply team and secured delivery from Northern

Ireland of a significant amount of gowns via the mutual aid process **[EL3/024 INQ000541346]**. The provided email chain indicates the discussion on mutual aid in early April 2020 and the actions taken to enable this sharing of PPE stock across the four nations.

74. A further example is managing a request from Wales for a range of PPE to meet their immediate needs and arrangements to make an emergency drop of the kit **[EL3/025 INQ000541348]**.

75. DHSC led on procurement, often on behalf of the four nations. There were regular four nations calls on PPE from April onwards. I provide an example agenda and outstanding actions log from the meeting on 7 May 2020 **[EL3/026 INQ000541363]**.

Private consultants

76. I was aware that PA Consulting was instructed by the Cabinet Office to carry out modelling, including in relation to modelling ventilator numbers. I liaised with Christian Norris who worked on the modelling and manufacturing numbers which were used by the ventilator supply team to inform purchasing decisions.

77. Throughout February and March 2020, NHS England worked on national and regional projections of PPE demand. I initially engaged McKinsey for ten days on a pro-bono basis to assist with this task, before DHSC subsequently contracted with McKinsey to build on NHS England's data and develop a demand model. McKinsey developed the modelling to include non-Covid-19 demand.

78. I initially engaged McKinsey as neither PPE Cell nor NHS England had the capacity to undertake demand modelling development. A large number of people had been redeployed from usual roles to assist with the pandemic response. Additionally, I needed people with specific expertise, particularly in supply chain distribution, problem solving, work planning and modelling, that I knew existed within McKinsey due to my previous employment.

79. Over time, the work that McKinsey had carried out on modelling the demand for PPE was transitioned into the work of Palantir, who had been engaged across NHS England to support the pandemic response with modelling capacity. I was not involved with the decision to engage Palantir. On the PPE workstream, they further developed a tool that was initially developed by the McKinsey team which took current supply and demand data and projected the availability of PPE over the next ninety days **[EL3/027 INQ000533134]**. It was re-developed by Palantir so that it would be compatible with other data systems being used in the team and across the pandemic response

(including the forward projection on Covid cases), avoiding the need for manual data entry. This directly connected supply and distribution information with the operational situation in the NHS and enabled; first, balanced decision-making about how much stock to distribute and how much to hold back for the next few days, and second, for the outputs of the 18:00 meeting to be directly transmitted to the distribution warehouse to fulfil orders. This was one of three tools used to run the PPE Cell, namely the PPE inventory model.

80. Deloitte provided a range of support on PPE. Their role was explained in a paper provided by DHSC for the PM's C-19 Strategy Meeting on 24 April 2020 **[EL3/028 INQ000541368]**. That included supporting the process of buying PPE from China, including regulatory checks, supporting the coordination of air freight shipments from China, supporting process map development and process definition since the second week in March 2020 and in terms of domestically produced PPE, establishing the qualification to PO process, agreeing sign-off processes and receiving and investigating offers to make PPE within England.

81. Deloitte had also supported work in preparation for EU Exit, including supporting the development and set-up of a Commercial Procurement Cell, the associated resource, materials and implementation plans, as well as the set-up and operationalisation of the National Supply Disruption Response ("**NSDR**") (see paragraph 147 below). Deloitte continued supporting the NSDR, which was extended as part of the pandemic response.

Engagement with Industry

82. I had limited engagement with industry on ventilators. I would have been on a number of calls where ventilator supplies from industry partners was discussed but I was not the lead. The main area of engagement with industry, aside from commercial discussions on procuring ventilators from suppliers and manufacturers both domestic and overseas, was the Ventilator Challenge and putting in place plans for domestic UK manufacturing. As indicated earlier, I had limited involvement in the Ventilator Challenge.

83. I had limited engagement with industry in relation to PPE. Initially, in the "all hands on deck" period, I spoke to some companies, including a company who usually made bikes but ended up making hand sanitiser. I recall one instance where we organised the import of a chemical needed for mask testing. I contacted Tate and Lyle on 23 March 2020 **[EL3/029 INQ000541340]** who connected me to one of their contacts in the Netherlands, who organised the next day overnight delivery to the Defence

Science Technology Laboratory at Porton Down, with a proportion of the amount being provided free as a sample. This correspondence is a good example of the kind of immediate action and response, and the extraordinary goodwill involved, as individuals and companies looked to do what was needed to support the country. As the PPE Cell increased in size, my direct contact with individual companies reduced, with individual commercial directors instead speaking to suppliers directly.

Section 5 – Procurement structures, systems and processes

84. This Section 5 explains the roles I had and the actions I undertook in relation to the procurement programmes for ventilators/oxygen and PPE. It sets out broadly a chronological approach which is interspersed with my comments on the procurement structures, systems and processes with which I was involved.

Ventilators

85. In respect of ventilators/oxygen, I set out my initial involvement in the ventilator procurement team, the checks that were carried out on potential purchases of ventilators (whether initiated by offers or otherwise), and the ventilator allocation procedure I put in place.

86. For an explanation of the types of ventilators and the terminology used to describe them, please see paragraphs 274 to 275 of the First Statement of Julian Kelly.

87. In terms of organisational responsibilities, DHSC was responsible for the sourcing and procuring of ventilators (and their associated consumables) during the pandemic and for the management of commercial relationships with suppliers and manufacturers. The only exception to this was in relation to the Ventilator Challenge for which the Cabinet Office was responsible. NHS England was responsible for the allocation of ventilators within England once they had been procured.

Initial involvement

88. I have set out the below in my Second Personal Witness Statement, but I reproduce it here for ease of reference.

89. On 5 March 2020, I took an action from that day's NIRB meeting to ensure NHS England and DHSC were connected on the resilience of the oxygen supply chain. I contacted Steve Oldfield that evening with an offer to discuss what oversight and support could be done together. Steve responded the next day, linking me with Chris Stirling at DHSC who was leading the task and finish group at DHSC tasked with procuring oxygen, oxygen concentrators and ventilators. The group had been active since 3 March 2020 and Chris provided me with his "end of day" summaries for the preceding days **[EL3/030 INQ000533064]**.

90. Also on 6 March 2020, NHS England's Chief Executive asked me to take a lead on the oxygen supply position (including ventilators) **[EL3/031 INQ000533063]**. I continued to liaise with Chris Stirling who provided a "Week 1 Summary" **[EL3/032 INQ000533066]** and an "Oxygen Problem Statement" **[EL3/033 INQ000533067]**. Both documents

assisted my understanding of the situation and actions to date and were updated and submitted as part of a deep dive into oxygen supply at the 10 March 2020 NIRB meeting **[EL3/034 INQ000269901]**.

91. From 7 March 2020, I joined the group's morning meeting to discuss the arrangements for deliveries into the country of newly procured equipment. I was getting more involved in the rhythm of the group and on 8 March 2020 I proposed an agenda for the next day's meeting **[EL3/035 INQ000533065]**. On 9 March 2020, following the morning meeting, I set out a list of actions the group had discussed and agreed, including splitting the group into four categories and establishing daily 8am calls **[EL3/036 INQ000533068]**.

92. The team included Adrian Eggleton, NHS England's National Estates Operational Lead, who advised from a technical engineering estates perspective. His focus was on VIE oxygen capacity. An explanation of VIE oxygen and its relevance to the provision of oxygen needed by NHS Trusts is set out at paragraph 319 of the First Witness Statement of Julian Kelly and I do not repeat that here. Very helpfully for me, Adrian and the team had mapped the whole chain from oxygen production, through delivery, to VIE capacity, the supply of oxygen through the pipes within NHS hospitals and the process by which that oxygen ended up being provided to patients in their NHS bed via a ventilator.

93. The team had been considering all points in the chain. As I became more embedded in the team, I understood that, due to steel production in the UK, oxygen production would not run out. Although transportation of oxygen to NHS Trusts was also unlikely to be an issue, I felt it prudent to develop a contingency plan to train army drivers who could drive the oxygen tankers should the need arrive (e.g. if supplies were depleted and extensive additional transportation capacity was needed, or if the existing tanker driver workforce suffered high levels of sickness leave and absence due to Covid-19).

94. There were concerns as to the capability of the pipes of the older buildings within the NHS estate to withstand the additional demands on oxygen flows that resulted from treating Covid-19 patients in the initial phase of the pandemic. Paragraph 323 of the First Statement of Julian Kelly explains the issue in more detail.

95. As a result of sufficient oxygen production and a low level of risk in transportation, the oxygen side of the ventilators/oxygen team were less focused on procurement activity and more on managing incidents resulting from the low levels of oxygen capacity within certain hospitals and improving infrastructure across the NHS estate.

96. Chris Stirling led the team's morning meetings which were attended by the DHSC supply teams for ventilators and oxygen (which also included NHS England employees) along with a number of clinical leads: Professor Ramani Moonesinghe; Dr James O'Carroll; Dr James Ramsay and Professor Andrew Menzies-Gow. Professor Ramani Moonesinghe is an emergency care anaesthesiologist and in the Relevant Period was NHS England's National Clinical Director for Critical and Perioperative Care. James O'Carroll is a consultant in anaesthesia and perioperative medicine and an honorary research fellow. James Ramsay and Andy Menzies-Gow are both highly experienced consultants in respiratory medicine. Andy was NHS England's National Clinical Director for Respiratory Services. Over time, other people joined the calls when specific topics were discussed, e.g. the provision of oxygen and ventilators to the newly established Nightingale hospitals. The team was known as the Oxygen Supply and Distribution Cell and the meetings were badged as the Oxygen/Concentrators/NIV - Task and Finish Group. An example of the matters considered at the 8am call on 27 March 2020 is provided **[EL3/037 INQ000541341]**.

97. Although the meetings had certain formal processes in place, they were not supported by a dedicated programme management team. Shortly after joining the meetings, I asked my Chief of Staff to ensure they were formally tracked and minuted. The meetings continued on a daily basis until July 2020.

98. As indicated in the slides submitted to the 10 March 2020 NIRB meeting indicating the status of the oxygen supply and distribution workstream **[EL3/038 INQ000533072]**, the impact and likelihood of not sourcing required ventilation devices was set at the highest risk level. The focus was on increasing the number of devices as fast as possible.

99. One of the initial problems I encountered after joining the team was that there was no recent indication of the number of existing ventilators, their make or their capabilities, available to the NHS. This information was needed to inform purchasing. Prior to the pandemic, NHS Trusts made individual purchasing decisions and there was no requirement for NHS Trusts to inform NHS England or DHSC of the number of individual items of healthcare equipment used or in stock at any given time. Part of my role was to provide that type of information to the team.

100. A ventilator survey had been conducted in 2017 and needed updating. I had no concerns about this; ventilator numbers are not data that I would have expected us to routinely collect and hold nationally. Trusts would have this information and we could update our survey quickly when required. As with all data collection requests to Trusts,

I am conscious that the utility of the information returned has to be balanced against the reporting burden on Trusts. In this case, a request for information had gone out in late February 2020 to NHS Trusts regarding the number of critical care beds that could be made available for NHS patients, and ventilator numbers were updated within a week. On 10 March 2020, I fed to Chris Stirling the information received from Trusts who had responded to the National Director for Emergency and Elective Care as to the number of ventilators in use and available **[EL3/039 INQ000533069] [EL3/040 INQ000533070]**.

101. In the first week of March, a figure of 7,357 ventilators, including adult and paediatric ventilators, those used for critical care beds and those in anaesthetic recovery rooms and other areas, was being discussed. Paediatric ventilators were suitable only for children, but it was not known at that time that children would be less impacted by Covid-19 and so less likely to be hospitalised needing ventilation. The First Witness Statement of Professor Sir Stephen Powis **[EL3/041 INQ000116811]** provides more detail on the numbers of ventilators available to the NHS at different times during the pandemic (paragraphs 439 to 446) and the activity undertaken to model the demand for ventilators (paragraphs 447 to 457). I do not repeat those paragraphs here.

102. It was clear that before I joined the ventilation cell, a decision had been made that more ventilators were needed, albeit in the context of then un-finalised information on the numbers of existing ventilators available to the NHS and the type of ventilators and associated equipment needed.

103. At this point little was known about Covid-19. The news was showing harrowing images of the developing situation in Italy. Alongside the impact that a lack of available treatment was having on patients, there was unprecedented global demand for ventilators. Trying to get something (in terms of ventilators) was better than nothing.

104. For example, the team had purchased a number of transport ventilators before I joined. These were ventilators usually used in ambulances for short periods of time, but with careful management, they could support patients in need. The team had also bought oxygen concentrators – a device that takes oxygen from the air and feeds it into a ventilator. These had been procured as a contingency measure in case of shortage of oxygen. As indicated above, it later became clear that oxygen supply was not an issue, but that was not known at the time. A number of these oxygen concentrators were later distributed to care providers, such as care homes, hospices and mental health facilities, that did not have piped oxygen supplies.

105. After domestic UK stock had been exhausted, attention turned to China - a significant manufacturing hub for ventilators. Over the course of March 2020, most of the world was attempting to place orders and secure supplies from Chinese manufacturers. As indicated earlier in the statement, I received invaluable assistance from the British Ambassador to China, Barbara Woodward, and the FCDO team located in Beijing. They provided professional procurement and logistics teams that secured a significant number of ventilators. They identified credible leads, were able to view machines in situ to confirm their existence, asked the necessary questions of the manufacturers and suppliers and sourced necessary regulatory compliance documentation in respect of the ventilators and export licences.

106. The bulk of activity in relation to Ventilator procurement took place in March 2020 with further activity continuing into April 2020. During May and June 2020, it became increasingly clear that the number of existing ventilators, coupled with those being produced via the Ventilator Challenge and those procured by DHSC, meant there would be enough ventilators to meet demand and reach the Government's target of 30,000. The extent of activity required for ventilator procurement, particularly sourcing from overseas suppliers, reduced accordingly.

107. On 25 June 2020 I was copied into to an email from Chris Stirling that attached the medium-term strategy for the oxygen, ventilation, medical devices and clinical consumables workstream **[EL3/042 INQ000541370]**. The strategy recommended that steps to ensure that the processes and response systems created for the first surge in Covid-19 demand remained available and should be enhanced for use in future surges. It also recommended the creation of a consumables stockpile containing products deemed at highest risk of shortage in coming months and for work to be carried out to develop a long-term strategy to reduce reliance on the global supply chain.

Checks on potential ventilator arrangements

108. When I joined, the DHSC ventilator team had already compiled a list of the usual makes of ventilator with their specifications, so it was known what each ventilator could and could not do. When an offer of ventilators was received, the first step was to check the ventilator's specification to assess whether it could do what was needed. Professor Ramani Moonesinghe (or in her absence, other clinicians on the team) would usually carry out this check and report back. This check included examination of quality assurance certification, whether the device had CE marking and whether it complied with MHRA standards for ventilators. Clinically related checks were also carried out,

such as noting oxygen flow rates and flexibility of breathing rate. This was a desk-based exercise using the documentation provided to the team. Professor Moonesinghe's First Witness Statement to the Inquiry provides further information in respect of the technical checks carried out and the "go/no go" recommendation output of that process.

109. The process extended beyond checking the offered device's specification. A quick but robust process was adopted to consider the relevant company's financial standing (by looking at financial records) and professional standards (by considering any investigations they had been part of), as well as any publicly available information about the company. Information was also sought on the availability of the devices – for example, at what stage of manufacture they were, whether they were ready to be transported, how many were available, and where they were located.

110. The checks were important in filtering out potential fraudulent offers. The team was under pressure from Government ministers to act quickly to secure genuine offers being made, but in certain situations there was a lack of evidence that the ventilators actually existed. We were often able to work with the FCDO to inspect the ventilators in person. There were occasions when a physical examination was not possible. Evidence of the existence and state of the ventilators would be sought, either by photographs or videos from the warehouses in which they were stored. The FCDO team's familiarity with the Chinese market meant they knew how to spot the less credible or even fraudulent offers. I provide an example of due diligence carried out by the FCDO team on an offer of ventilators that led to a decision not to engage in negotiations **[EL3/043 INQ000541347]**.

111. As with the example above, the checks sometimes yielded information, such as scepticism as to whether the ventilators existed at all, that led to decisions not to proceed. This was especially the case in late March/early April 2020, as the asking prices rose to unprecedented levels due to buyers outbidding each other. On one specific occasion, a decision to transfer money was made in respect of a batch of ventilators, but it subsequently became clear the ventilators could not be supplied. Happily we were able to get the money back. This related to a proposed purchase of 3,000 ventilators from China, via an established healthcare distributor in Malta, Cherubino Limited. I recall that a deposit payment was made into an escrow account in early April 2020, but that it became apparent that the ventilators could not be supplied (possibly because the Chinese supplier had oversold), and so HMG withdrew from the proposed transaction and reclaimed the deposit from escrow. I provide two

relevant emails from 7 April 2020 and 9 April 2020 **[EL3/086 INQ000563697] [EL3/087 INQ000563698]**.

112. There was a robust approval process in place with the DHSC finance team which I outline further in Section 6 of this Statement. I made recommendations to the DHSC Accounting Officer or DHSC Directors of Finance. At no point did I make the final decision on a deal or offer for ventilators. Those involved in the clinical specification assurance process, Professor Moonesinghe and those in her team, would provide a "go/no go" recommendation. This was not an indication that the offer should be accepted without further consideration, it was simply an indication that the necessary assurance on the aspect of the offer they were considering had been met. The offer then went through the various other assurance processes before landing with DHSC officials for a final decision.

113. There was considerable cross working between Government departments. I have indicated earlier in this Statement that in late March/early April 2020, I regularly attended the daily C-19 Strategy Meetings with the PM. I also attended a number of calls and meetings with Michael Gove, then CDL. I have also described earlier in this Statement the first call I attended on 14 March 2020 to discuss how the Cabinet Office could help DHSC on ensuring equipment was sourced in the most effective way possible. There were a number of follow-up calls and meetings to discuss resulting actions.

114. From 17 March 2020, the Oxygen and Ventilation Situation report was circulated **[EL3/044 INQ000541371]**. The report was a spreadsheet, updated daily, setting out updates on various workstreams relating to ventilator procurement, including conventional procurement (new deals with suppliers, manufacturers and intermediaries), the Cabinet Office's Ventilator Challenge, ventilator consumables and later the "PO to Ward" process (how to allocate procured ventilators and manage NHS Trust engagement processes). I provide an example of how the sit rep evolved during April 2020 **[EL3/045 INQ000541357]**.

115. In the third week of March 2020, I indicated that a care package should be sent to hospitals alongside the distributed ventilators. This would include any necessary fluids, masks, tubes, etc. The aim was to reduce the need for hospitals to have to search around before being able to use the ventilators. Initially members of the team, including Ramani and James, were compiling lists of the consumables needed. Subsequently, a couple of people were brought into the warehouse in the Midlands that was rented from the army to assemble the packages.

116. The nature of the SRO role required me to:

a. Be very structured and focused - I helped the team prioritise where to direct their time and energy; and

b. Be the senior voice who could shield the team from interruptions. For example, I could direct those seeking to contact the team directly about offers to the relevant email address, making clear that the process needed to be followed regardless of whether that might take more time than they might wish. That became more important over the subsequent couple of weeks as Government ministers were bombarded with offers to supply ventilators from many varied sources, including from very senior international contacts that were seeking deals with the UK and which were passed to the team for processing.

Allocation of ventilators

117. Despite the DHSC efforts to source additional ventilators, first from suppliers in the UK and later internationally, some NHS Trusts were attempting to procure their own ventilators. I had to speak directly with some NHS Trusts' Chief Executives to explain that it was better to source the ventilators nationally to ensure the hospitals that needed them most received them. If they continued to individual buy, I asked them to indicate how many they had and whether they were being used.

118. As the peak of the first Covid-19 wave approached, I felt it necessary to put in place a process for how NHS Trusts were allocated the procured additional ventilators.

119. I focused on the data gathering and building a data system to track NHS Trust's positions on ventilators. For any NHS Trust wanting additional ventilators, we used data on the growth rate of inpatients with Covid-19 and asked the Trust for a stock-take of the number of ventilators in use or stored at the hospital. Over time we built an understanding of what individual NHS Trusts had, what ventilators they could handle and what they didn't need to handle. This enabled us to build a picture of the position of each of the seven NHS England regions of England.

120. We set up regular calls from 1 April 2020 with a ventilation lead from each of the seven regions. Draft terms of reference for the National Ventilator Allocation Group (as it was called) were circulated on 2 April 2020 **[EL3/046 INQ000541343]**. It was usually chaired by Keith Willett because I wanted a clinical decision-maker in that role. Certain areas, e.g. London, were under severe pressure at that time. The main goal of the meeting was to make clear that allocation had to be backed by the evidence to make sure the limited supplies went to those Trusts most in need. In the first few days of the

meeting, the data was sometimes queried by those on the call or indirectly by the Trusts involved, so in some instances we deferred decisions and required a return for the next day's call with the data.

121. The Palantir team offered to help make the data live in the meeting to facilitate informed decision making. Within a matter of days, we got to the point of having a list of all the hospitals in the country which you could click on and it would show the existing data. Given Covid cases were progressing through the country, we asked for this to have an element of geography and the next day this data was presented in map form. Within a week, we had the process fully up and running. It was referred to as the National Ventilation Allocation Programme ("**NVAP**"). The meetings were held at 3pm each day. I provide the agenda and actions list from the 3pm meeting on 9 April 2020 **[EL3/047 INQ000541351]**. Any bids for additional ventilators had to be submitted by 2pm to enable them to be plugged into the model, such that in the 3pm call we would have a list by region of all of the hospitals that had submitted bids. The 3pm meetings would systematically work through the asks. A Standard Operating Procedure was created for the NVAP. Drafts were circulated for comment in the first week of April 2020, with a final version published on 7 April 2020. I provide the second version published on 1 September 2020, which indicates the changes to the first version **[EL3/048 INQ000541372]**.

122. By mid-April 2020, we had a much better forward view of the numbers of ventilators expected to arrive in country. This was mainly due to Shanghai airport's very rigorous process of checking the manifest against what was in the warehouse and carrying out quality control checks before putting the ventilators on the plane. That meant we knew approximately three days in advance how many of which type were to be transported. Adding the flying time meant we knew when and how many additional ventilators would arrive. Procurement activity subsequently scaled down, due to it becoming clear the peak of patients admitted to hospital with Covid-19 had passed, the increasing difficulty of obtaining unsold ventilators and because it was clear that the Ventilator challenge was going to start producing ventilators. The only deals that went through after that were ones that were so well progressed it didn't make sense to cancel, or that were for more specialised ventilators for specific treatments.

123. As indicated earlier in this Statement, during May and June 2020, activity relating to procurement of ventilators significantly reduced as it became clear that demand was met and the Government's target of 30,000 ventilators would be achieved.

Oxygen

124. I have not been asked to provide any detail in respect of oxygen procurement. As SRO of the vents and oxygen cell, it fell under my remit. However, prior to me joining the team, it had been established that supply of liquid oxygen to Trusts would not run out. As such, there was little in terms of procurement of oxygen that required my input.

125. The focus for the oxygen team after I joined was arranging for engineering works in respect of, and responding to incidents in relation to, the state and age of oxygen pipes within hospitals which limited the amount of oxygen available for use with patients. Further details of the work undertaken in respect of oxygen and incidents of limitation of oxygen supply within Trusts are set out at paragraphs 340 and 341 of the First Witness Statement of Julian Kelly.

PPE

126. In respect of PPE, I set out below my initial involvement with the PPE Cell and how I managed offers and referrals.

127. This Section repeats wording contained in my second witness statement as it is also relevant to the questions I have been asked in my Second Module 5 Rule 9 Request.

128. DHSC took on responsibility for procuring and distributing PPE supplies to providers of NHS services early in the pandemic.

Initial involvement

129. In early March 2020, NHS England became aware of concerns from NHS Trusts that their PPE orders from NHS Supply Chain (run by SCCL) were not arriving on time. As a result of these concerns, on 10 March 2020, NHS England's Chief Executive asked me to investigate issues arising with PPE and discuss these with DHSC. I have provided an email chain which includes a note from NHS England's National Head of Emergency preparedness, resilience and response ("**EPRR**"), to DHSC on 12 March 2020 **[EL3/049 INQ000533074]** which indicates the types of issues being experienced, including that an order for facemasks had not arrived and that in certain regions there were issues with access to various types of PPE.

130. My role was not defined at the outset. I set out below the actions I took in investigating the issues as I became more involved in the PPE procurement activities. Paragraph 153 summarises my perception of the issues that existed with PPE supply and what needed to be done to rectify them.

131. I learned first that the Pandemic Influenza Preparedness Programme's ("**PIPP**") stock of PPE managed by Public Health England was being released in a controlled way to providers of NHS services, but that this was not enough to meet the current or projected PPE demand and NHS Supply Chain had been ordered to procure more PPE from its suppliers. My non-executive director position at SCCL, coupled with the fact I was Chief Commercial Officer at NHS England, meant I was well-placed to liaise quickly with senior SCCL executives. I attended an SCCL Board Meeting on 11 March 2020, but the operational response of SCCL to Covid was not discussed in any detail **EL3/050 INQ000533078]**.

132. I was concerned that SCCL was not anticipating, was not planning for, and had only partial information on future stocks of the amounts of PPE that would be required. My concerns relating to SCCL were confirmed after I had discussions with the CEO and Chair of SCCL on a follow-up call. These discussions also identified that there were challenges with distribution of PPE from SCCL warehouses. At the time, Unipart was the contractor responsible for the warehousing and distribution of SCCL-supplied products to NHS Trusts.

133. In the evening of 11 March 2020, I discussed with Steve Oldfield at DHSC the concerns being raised by Trusts. I had been working closely with Steve and his team the previous week on the oxygen and ventilators work and I was keen to ensure there was a joined-up approach on PPE by NHS England, SCCL and DHSC. This is indicated in my 12 March 2020 email exchange with David Simmons, who was organising the DHSC supply teams arrangements **[EL3/051 INQ000533073]**.

134. I learned that the lead for the DHSC team working on PPE supply had to take sick leave on 13 March 2020 without there being an obvious replacement. I discussed with Steve Oldfield over the course of the following couple of days that there was not a senior manager managing the PPE response and reiterated to him my concerns arising from the SCCL/Unipart situation.

135. On 14 March 2020, I discussed with Steve the need for SCCL to ensure the PIPP stockpile was released such that Trusts received their orders, and the need for SCCL to liaise with NHS England and DHSC on any issues arising from that **[EL3/052 INQ000533075]**. This was followed the next day by discussions with the Chief Operating Officer at SCCL who explained their approach of restricted supply and the issues SCCL was experiencing, including that Trusts were not being told of supply restrictions **[EL3/053 INQ000533076]**. SCCL reiterated their perspective in an update provided to me and other senior people within SCCL on 16 March 2020 **[EL3/054**

INQ000533077; EL3/050 INQ000533078]. I was, at that time, receiving reports from regions indicating that Trusts were running very low on particular types of PPE. For example, on 16 March 2020, Oxford University Hospitals indicated that it had only two days' supply of surgical masks and long-sleeved scrubs **[EL3/055 INQ000533079]**. Another example is Great Western Hospitals indicating on 17 March 2020 that it only had enough masks for one day **[EL3/056 INQ000533083]**.

136. Also on 16 March 2020, I had discussions with Steve Oldfield, Sarah Parker at DHSC and Lois Shield in the commercial and procurement team at NHS England, on a possible public call for PPE **[EL3/057 INQ000533080]**. I highlighted the potential need for a database to be set up so that offers of help could be appropriately routed as they came in. I was starting to receive offers relating to PPE that others were forwarding to me. One such offer came in on 17 March 2020 and related to a significant number of facemasks from China. The referring email highlighted the need for speed in responding to the offer. As I had with other such offers, I forwarded this to Sarah Parker at DHSC and at the same time queried if there was a dedicated mailbox for such offers **[EL3/058 INQ000533081]**.

137. The next day Sarah indicated that any offers to help from companies were to be sent to an individual at NHS Supply Chain (SCCL) who would route them to the relevant team within SCCL **[EL3/059 INQ000533085]**. As a result, I asked my team to forward any offers in my inbox. I provide an example of an offer being forwarded **[EL3/060 INQ000533086]** and in which I asked if the individual wanted to set up a separate mailbox for all the offers that were coming in. This was swiftly followed by an email on the same day from that NHS Supply Chain individual indicating that offers should be referred to a third person at NHS Supply Chain who would do the "first sift and tracking" **[EL3/061 INQ000533088]**. Later the same day, I was informed that any offers should be forwarded to the central NHS Supply Chain inbox - suppliers@supplychain.nhs.uk. I flagged in an email to SCCL and DHSC on 18 March 2020 that we needed to make sure that there was capacity to handle all the offers coming in **[EL3/062 INQ000533087]**.

138. In the evening of the same day, 18 March 2020, I received an email from Steve Oldfield's office indicating that any offers of help from companies or individuals for anything non-ventilator related could be sent to gcfcovid19enquiries@cabinetoffice.gov.uk **[EL3/063 INQ000533089]**. The email indicated that BEIS had set up the inbox and Cabinet Office commercial staff were

staffing it and triaging requests. The email indicated that there was a plan to put a reference on GOV.UK to point people to this address.

139. Early on 19 March 2020, David Simmons highlighted the two mailboxes above and sought to clarify the remit of each **[EL3/064 INQ000533090]**. The matter was to be discussed on the morning meeting (the morning meetings are referred to in more detail below). From the outputs of this meeting **[EL3/065 INQ000533092]**, I cannot see that this was definitively determined and I note from my emails that there are a small number of subsequent offers forwarded to the suppliers@supplychain.nhs.uk address after this date. The sending to different recently used mailboxes is likely simply an indication of the speed at which I and my team were trying to clear my inbox. By 26 March 2020, I was telling people that the suppliers@supplychain.nhs.uk address was not the right address **[EL3/066 INQ000533115]**.

140. Going back a couple of days, on 17 March 2020, I was called to a meeting with Michael Gove, then CDL, and others. While it was predominantly to discuss ventilators, it also touched on the SCCL position on PPE. After the meeting, I had a discussion with Gareth Rhys-Williams, then Chief Commercial Officer for the Civil Service, in the room opposite CDL's office. I explained my concerns, including that the most urgent issue for NHS Trusts was distribution and logistics rather than supply. I was sure that supply would be a problem, but distribution and logistics were the immediate concerns. Gareth and I called the CEO of Unipart. Although Unipart had already upscaled staffing in their logistics centres, this was insufficient to meet the throughput required to meet the needs of NHS Trusts. Unipart took on board the concerns raised on the call and went to assess what would be possible. The next day, 18 March 2020, they informed us that the layout and set up of their warehouses would not allow any further increases in throughput and capacity. It was becoming very clear that the existing arrangements for procuring and distributing PPE would not be sufficient to satisfy demand.

141. Also on 17 March 2020, Steve Oldfield and I spoke privately to Jim Spittle, Chair of SCCL, to raise our concerns on appropriate stock allocations to Trusts and that the pandemic necessitated a new way of working from SCCL. Jim set up a call for the next day between Steve Oldfield and I and the SCCL leadership **[EL3/067 INQ000533084]** to discuss the realities of the underlying situation, the current approach to supply and distribution and to agree an emergency plan. On the call, on 18 March 2020, SCCL asked Steve Oldfield and I to confirm that we did want further release of supply from the PIPP stock. We confirmed that Trusts were short of supply now, that staff needed

protection and that further releases should be ordered. This was then coordinated with Public Health England ("**PHE**") who managed the PIPP stock, not just on behalf of the NHS but with other users such as social care.

142. By 18 March 2020, given the urgency, I had already asked McKinsey to arrange a team to assist on developing a demand tool for PPE that would provide estimates of the demand level for different types of PPE. DHSC subsequently formally contracted with McKinsey for this work. I initially engaged McKinsey as neither the PPE Cell nor NHS England had the capacity to undertake demand modelling. A large number of people had been redeployed from usual roles to assist with the pandemic response. Additionally, I needed people with specific expertise, particularly in supply chain distribution, logistics, problem solving, work planning and modelling, that I knew existed within McKinsey due to my previous employment, and indeed McKinsey were able to immediately provide me with a logistics expert with the skills I needed.

143. I had considered whether the army could assist with logistics and McKinsey put me in touch with the Chief of Staff to the Chairman of the Defence Staff. This led to my Military Aid to the Civil Authorities ("**MACA**") request on 19 March 2020, which underwent some discussion and clarification **[EL3/068 INQ000533093] [EL3/069 INQ000533091]**, and led to Brigadier Phil Prosser (now Major General) and 101 Log joining us to work on PPE logistics. Over the course of the weekend (21/22 March 2020), 101 Log fed into an assessment on whether the PIPP stock, SCCL and Unipart would be able to deal with the PPE storage, processing and distribution that was expected to be needed. It became clear that the existing arrangements could not be scaled-up to the required level due, in most part, to the way the warehouses (those run by Unipart and the PIPP warehouse run by a contractor to PHE) were set up. An alternative supply chain therefore needed to be established.

144. In terms of my involvement with the PPE team at this point, I established a daily routine of 8.30am calls on PPE from 19 March 2020. Before this, calls had been happening at varying times of day with varying agendas. Both pre and post 19 March 2020, calls were attended by a range of team members. The calls were at that time relatively unstructured. I started to reshape them to focus on identifying issues, allocating tasks and following up on the previous day's concerns. I provide an example of the outputs of the 8.30 call on 23 March 2020 **[EL3/070 INQ000533097]**. This email also gives an indication of the individuals that participated in these calls.

145. In the middle of the following week, Brigadier Prosser volunteered to start chairing the calls to put more structure in and to allow me to concentrate on the content of the call

as opposed to the structure. From the following week, we also assigned clearer roles and structures within the team and on the calls and moved to a standard daily agenda. I provide an example from 27 March 2020 of the one page slide that was developed to inform the 8:30 calls **[EL3/071 INQ000533117]**.

146. Once we had agreed this structure, the calls became the daily project management structure. They focused on reviewing the work plan including the 'buy' list based on that day's intelligence, the current 'demand' pressure in the system, deal availability, what products were a priority for buying and what minimum quantities were needed. They also covered progress on establishing the supply chain, improving procurement processes, and identified any needs for cross-government coordination.

147. The calls included representatives from NHS England, DHSC, SCCL and Cabinet Office. The calls included reports from those supporting the NSDR centre (the facility handling urgent requirements from providers for PPE – more detail is set out in the First Statement of Julian Kelly) who gave us important insights on the emergency calls being made by Trusts and other organisations requiring PPE urgently. I provided advice and guidance in these meetings, particularly from an NHS demand perspective but also on the credibility and likelihood that offers would materialise into delivered PPE that met the required specification. The structure of these calls became more defined and they moved to Microsoft Teams, which made it easier to review reports on PowerPoint charts and to have open discussions while some of the team worked remotely. By 31 March 2020, a data dashboard was included that set out, for individual PPE types, the number of units of PPE that were in various stages of being ordered from existing SCCL suppliers, from new suppliers not on the SCCL list, and those being manufactured under the "make" approach **[EL3/072 INQ000533119]**.

148. Also on 19 March 2020, daily calls at 18:00 with the PPE team were added. Initially these were standard project management type 'check out' calls to review the tasks carried out that day and to task for urgent overnight issues. On 8 April 2020, we clarified the use of these calls, as those focused on supply and distribution decisions, and subsequently we referred to them as the "allocation meeting". I provide the read-out from the allocation meeting held on 10 April 2020 **[EL3/073 INQ000533122]**. Initially these were chaired by me or by Phil Prosser. As the focus changed, they changed to being chaired either by me or by Jonathan Marron of DHSC. Jonathan became the SRO of the PPE sub-category within DHSC's supply workstreams in the week commencing 30 March 2020.

149. The evening meetings, once re-focused, covered reviewing the overall situation, considering demand and stocks, and making distribution allocations to be enacted overnight. The call usually included representatives from NHS England, SCCL, Unipart, 101 Log, PHE and McKinsey.

150. Over time, the work that McKinsey had carried out on modelling the demand for PPE was transitioned into the work of Palantir, who had been engaged across NHS England to support the pandemic response with modelling capacity. On the PPE workstream, they further developed a tool that had been initially developed by the McKinsey team which took current supply and demand data and projected the availability of PPE over the next ninety days (see paragraph 79). It was re-developed by Palantir so that it would be compatible with other data systems being used in the team and across the pandemic response (including the forward projection on Covid cases), avoiding the need for manual data entry. This directly connected supply and distribution information with the operational situation in the NHS. This enabled balanced decision-making about how much stock to distribute and how much to hold back for the next few days, and also enables the outputs of the 18:00 meeting to be directly transmitted to the distribution warehouse to fulfil orders.

151. Returning to the PPE supply and distribution situation, it became clear by mid to late March 2020, as laid out above, that the existing supply chain was not capable of delivering anticipated PPE requirements and a separate supply chain was needed. DHSC established this supply chain (which, after the fact, has been referred to as the Parallel Supply Chain) which had the aim of urgently and centrally sourcing and distributing PPE to providers of NHS services.

152. A multi-organisational team grew in numbers over the next couple of months to approximately 450 staff, who were tasked with finding and buying PPE as part of the new supply chain with a new distribution supplier (Clipper logistics), and a new approach was being put in place with assistance from the military.

153. I have set out above a detailed explanation of the actions I undertook to understand the problems that existed in the PPE supply chain from 10 March 2020, when I became involved, until 19 March 2020, when I set up the morning and evening meetings which provided a steady daily rhythm to the work. As a summary, I set out below the problems I had encountered in that in relation to different parts of the supply chain:

    a. **In procurement:** SCCL's existing suppliers were mainly wholesalers – companies acting as intermediaries between manufacturers of PPE and SCCL's

end users, which were NHS Trusts. PPE was a commodity and hence a wholesale market had arisen where intermediaries consolidated supply from manufacturers and sold products on into the relevant market. They bought in a 'just in time' fashion – i.e., in many cases they would agree to supply SCCL with a volume of a product that they did not yet own. They could then buy the product on the open market in time to supply the order. The challenge SCCL therefore had with its existing suppliers was that its suppliers had standing orders into SCCL which were not backed with product until near the time for the sale to complete. As the supply had suddenly become constrained, these suppliers were defaulting on deals at short notice, or were no longer able to supply, even as SCCL attempted to increase their buying to meet the enormous uplift in demand from health providers. I provide an email from 17 March 2020 from SCCL that indicates the extent of the uplift in demand **[EL3/074 INQ000533082]**. To deal with this we (DHSC) established a buying cell, separate from SCCL, to contract with new sources of PPE. Initially the intent was to keep the SCCL buying of PPE from their existing suppliers running in parallel with this, but over the following 10 days that became too complex and so all PPE buying was folded into the 'parallel supply chain'. The tremendous challenges of buying PPE in the global market in the March to winter 2020 period are detailed in the First Statement of Julian Kelly and elsewhere.

b. **In planning supply to meet demand:** SCCL's systems were not fit-for-purpose for this challenging environment, as they had no way of tracking the delivery of products into the UK once orders were placed. This meant that even though SCCL placed additional orders in February and March 2020, the PPE Cell had no way of being sure when they would arrive, or that the deliveries would arrive at all. In the near term, we addressed this through manual tracking (i.e. by someone picking up the phone and directly asking questions of the relevant organisation/person as to the status or whereabouts of the PPE and anticipated delivery dates), including of the orders fulfilled in China by British government officials, and by directly contacting the companies fulfilling orders for SCCL to ask for tracking information. Subsequently, from May until July 2020 a new system was contracted for and installed to ensure all orders could be tracked into the country.

c. **In quantifying demand:** Given NHS England was not the buyer or supplier of PPE, it held no information about usage or stocks of PPE held in Trusts at the start of the pandemic. SCCL also had historically not needed this information,

and Trusts often had not needed detailed information as PPE was a low cost, commodity item that could, in normal course of business, be ordered overnight when needed. The PPE Cell therefore did not know, other than from the previous pattern of Trusts orders to SCCL pre-pandemic, what demand might be expected. As outlined above, I commissioned McKinsey to model the expected demand based on infection, prevention and control (IPC) guidance as to what PPE should be worn in different situations and by which staff, with respect to the current incidence and growth rate of Covid cases in a Trust. This model was tested with clinical and other staff to ensure it was practical, and then tested in practice to see how close it got to what hospitals said they needed. Over time, this demand model was also expanded to cover social care, hospices, primary care (with substantially less detail) and some other users. Before the model became operational, initially Trusts were ordering what they thought they needed, but this didn't necessarily correlate with demand and supply. We moved to 'push' supplies in the week of 30 March 2020, where every Trust would get a delivery of all core elements of PPE, sized by size of Trust and their previous ordering, delivered every three days. Once the model became more robust, we used that to size the push orders. Later in the process, we moved back to Trusts being able to order what they needed, but those orders were occasionally adjusted based on availability in times of shortage.

d. **In ensuring Trusts (and later other users) had sufficient PPE stock:** Given that we didn't nationally hold local inventory information about PPE in March 2020, we worked quickly to identify a way to make it easy for them to do so, partly to help with our distribution, but also to ensure local mutual aid could operate effectively. Palantir developed the PPE stock tool which was piloted in the North West during late April 2020 and rapidly rolled out across the system. The challenge we did not address was that of distribution within a Trust, which was managed locally by Trusts. In the near term, the NSDR emergency line was set up, which allowed Trusts (building upon NSDR's original application in relation to EU Exit) and, later, other organisations, to put in emergency requests for kit when they saw they would run out in the very near term (within 24 hours).

e. **In distribution to users in England.** As outlined above, the distribution systems that existed at the start of the pandemic did not have the ability to scale to the requirements of the pandemic. To address this, we contracted with Clipper Logistics to build a separate supply chain for PPE in England, transferring SCCL's existing stock and orders to this new warehouse. In addition, we set up

alternative ways for non-Trust users to receive PPE, including the establishment of the PPE ordering portal for lower volume users. For example, by 4 August 2020 over 60% of GP practices were registered on the portal **[EL3/075 INQ000533137]**. Initially, social care was supplied through DHSC's pandemic route of the PIPP stock being released to wholesalers who then sold into the social care market. This proved insufficient, so social care were later set up to access supplies via the new distribution system.

154. The parallel supply chain (as it became known later) sought to obtain PPE directly from manufacturers where possible, although it also dealt with many new intermediaries that were not part of SCCL's existing supply chain. SCCL initially continued to buy through its existing structures from existing suppliers, although this was transferred to the parallel supply chain team by early April 2020.

155. China was by far the main PPE manufacturing hub pre-pandemic, and efforts to obtain PPE through new suppliers naturally started to home in on the Chinese market. This included considerable on-the-ground support from a team set up by the British Embassy in Beijing, and logistics support in Shanghai.

156. It must be noted that the world market for procuring PPE from manufacturers or intermediaries from China and other countries was extremely 'hot'. Deals often failed within minutes of being confirmed due to being outbid by other buyers. PPE was in extremely high demand, not just for the healthcare sector, but for all workers in all sectors in the worldwide economy.

Managing offers/referrals

157. In addition to taking steps to source PPE from manufacturers and new intermediaries, everyone working within the PPE team was subject to hundreds of direct offers and referrals of offers. These offers included supplies already within England or the UK and PPE located in other countries. Not all were offers to sell PPE to the NHS. The PPE team also received many offers of donation of PPE in varying quantities.

158. In my second witness statement to the Inquiry, as an example of the multitude of offers/referrals that needed managing, I provided a list of all offers/referrals received by me that I then forwarded on a single day (23 March 2020), with an indication of to whom they were sent and why.

159. A webpage had been set up by the government's Crown Commercial Service ("**CCS**"), separately to DHSC or the PPE Cell, which allowed any individual or company to make contact with offers, and I believe this fed the contact into a portal. Offers believed to be

concerning PPE were then sent on to the PPE Cell to be reviewed. However, the sheer volume of offers was so high that it became impossible to sift and locate the more credible ones with any speed.

160. I tasked three teams in Skipton House (NHS England's London offices) over the weekend of 21 and 22 March 2020 to consider how to solve some of the problems we were facing. Specifically:

    a. one team composed principally of Cabinet Office individuals, was to review how we would manage the whole flow of PPE orders, including the backlog of PPE offers that had already built up;

    b. a second team to look to see if the buying process could be made more responsive and agile while ensuring technical and commercial processes were still applied robustly; and

    c. a third team, part of the buying team with Hannah Bolton, to start to try to identify which offers that had the greatest possibility of coming to fruition.

161. This work continued into the following week.

162. For the first team, it was imperative that we had a method of cataloguing the offers that came in, including cross-cataloguing those from the CCS database and those that were existing suppliers to SCCL, filtering the huge numbers of offers to identity those most likely to be able to provide the types and volumes of PPE within the timescales needed, tracking their progress through the commercial process, and, in some instances, reporting back to referrers what had happened to the offers they had referred. The Cabinet Office team that reviewed this need over the weekend of 21 and 22 March 2020 decided to build a bespoke CRM system. This was progressed for a few weeks, but eventually they decided to use an off-the-shelf case management software tracker. However, this didn't become operational until over a month later.

163. In the meantime, we generated a dashboard on the backlog of offers and reported progress on clearing it at our daily meetings, but it was clear that the work involved in reviewing each offer would not return sufficient actual buying opportunities to make this activity an effective solution to the supply challenges being experienced.

164. We urgently needed some way of prioritising and tracking which offers would be prioritised to enter into the commercial process, tracking their progress, and reporting to referrers where necessary. I have set out in my second witness statement the direction that I gave the team in setting up the trackers or prioritisation approach. I also

set out the need to deal with offers and referrals in a way that minimised noise and gave as much confidence as possible that the programme would deliver. This included feeding back to those referring offers to the team.

165. My second witness statement also sets out the approach adopted when forwarding on offers or referrals of PPE.

166. All offers or opportunities, regardless of how they came about, were subject to the same technical assurance and financial diligence before any decision was taken to award a contract, as explained below. The process that applied when an offer or referral was received has been set out in paragraphs 26 to 54 of the Judgment of Mrs Justice O'Farrell in the Queen on the application of Good Law Project Limited and Everydoctor and the Secretary of State for Health and Social Care, known as the "Pestfix Judgment" **[EL3/076 INQ000533144]**, but I set out a summary of the process below as there are a number of questions in the Second Module 5 Rule 9 Request that relate to the process.

167. There were a number of teams within the PPE Cell, each with a specific area of activity. The "Buy Team" were responsible for identifying credible offers. They would utilise the "Opportunities Team" who would consider the offers/referrals received via the webpage. The Buy Team would also consider leads from overseas, particularly the information coming from Barbara Woodward and the FCDO team in China. The Buy Team were comparing the products offered with the products being sought by the NHS. They would investigate the numbers of products available, the ball-park price, delivery times, etc.

168. Once a seemingly credible offer/referral/lead had been identified, the Buy Team would pass it to the "Technical Assurance Team". This team would consider the extent to which the products being offered met the relevant specification and regulatory requirements. The Opportunities Team would sometimes be able to source the specification or regulatory information when engaging with the potential supplier/manufacturer. The FCDO team in China often assisted with obtaining the necessary information direct from the Chinese suppliers. The Technical Team worked with MHRA and/or HSE if, for example, the product was indicated to be of "equivalent standard" to a particular requirement.

169. Financial diligence was undertaken at different times and by different teams depending on the circumstances of a particular deal. The "Closing Team" were often involved, but the Buying Team may also have requested financial standing information from the supplier as part of the initial engagement. Often, little was known about the specific

company, e.g. because they were located and operated abroad or they were not a usual supplier to the health sector. Regardless of which team carried out due diligence, searches would be undertaken of publicly available documentation to identify any risks, such as the potential for the company to become insolvent after making payment but before receiving the products. Anything that suggested a risk would be flagged. It did not necessarily mean the offer was rejected, but it would feed into consideration of the overall risk position.

170. The Closing Team would also work on the contracts to be signed with the potential suppliers. This included negotiations on price, agreeing payment mechanisms, and other contractual terms such as delivery. It was the Closing Team's responsibility to prepare a pack to go to the ultimate decision-maker – the Accounting Office or Finance Manager. Packs were only prepared for deals that were considered suitable. If the deal had been rejected for any reason before this point, they would not be presented to the final decision-maker.

171. There was also a "Deals Committee" which would, for deals over a certain financial threshold, consider the pack before it went to the Accounting Officer for approval.

172. As SRO, I made decisions on a range of operational matters, but I did not become involved in the individual tasks of individual teams listed above in respect of individual opportunities. I was focused on ensuring the process continually ran. I was frequently copied on emails which included offers, and my team worked through my inbox regularly to forward these on to the buying teams to ensure every offer was appropriately reviewed.

173. As indicated above, part of my, and the DHSC SRO's, role was to make recommendations to the Accountable Officer in respect of opportunities. It was the role of the Accountable Officer to make the final decision on award of contracts. My recommendations were primarily driven by whether a particular offer would provide the types of PPE needed by NHS provider organisations, bearing in mind current stock and delivery timescales. Financial assurance of the offer and technical assurance of the PPE being offered were matters for the respective teams who would investigate and provide their output for inclusion in the pack for consideration by the final decision-maker. I provide more examples of my input in relation to deals and the factors/risks considered by the final decision-maker in Section 6 of this Statement.

174. Efforts to source PPE continued beyond Wave 1. At different times in different categories, we faced further buying challenges as 2020 progressed. These included shortages of particular mask types in May and July 2020 and of gloves in August 2020.

175. Leading up to the production in May 2020 of a comprehensive PPE Sourcing Strategy produced by the Cabinet Office (see paragraph 56), I provided input and supported production of the strategy along with other NHS England and DHSC staff. During my involvement in PPE, I made no final decisions on PPE policy.

176. NHS England separately took the initiative to consider if and how PPE could be reused. At the end of May 2020, a pilot was set up for reusable gowns with several Trusts. I provided guidance on the approach and style of documentation.

177. At the 12 October 2020 oral evidence session to the Public Accounts Committee, I indicated the then position on PPE procurement **[EL3/077 INQ000087462]**. I explained that the focus of the PPE strategy that had been published on 29 September 2020 **[EL3/078 INQ000541373]** was on building up sufficient supplies for the winter. By this time, for most items, there was already four months of supply either in the country or with UK-based manufacturers. The four months' supply was to meet the demand for PPE from across the health, social care and in some instances other Government departments as well. I confirmed I was '99%' sure that that would be the case for all items by the beginning of November 2020. Work was being done with Trusts to make sure that they did not just have a set of items, but that they had particular items that were actually required. I also explained that the PPE portal continued to be developed so that smaller volume users, such as GPs and smaller social care homes, could order exactly what they needed via the portal.

178. My role in relation to PPE lasted until I was asked to lead the Covid-19 vaccination deployment programme on 9 November 2020. My involvement in PPE supply and distribution ceased at this point.

Section 6 – Award and value of contracts

179. This Section 6 sets out my role in the award of contracts for ventilators and PPE.

180. For both ventilators and PPE, my role was to provide recommendations to the decision-maker, as set out above. Final decisions on whether to buy were ultimately made by DHSC, DHSC Accounting Officers or DHSC Directors of Finance. I did not make any final decisions in relation to any offers of ventilators or PPE.

181. On one occasion, one of the PPE team confused my recommendation of a deal to the DHSC's Director of Finance with a final approval to contract with the supplier. This related to an offer from KAU Media. I provided my recommendation on 10 April 2020 **[EL3/079 INQ000533124]**, but it was erroneously referred to as me giving "*approval to proceed with this contract and order without QA* [quality assurance] *approval*" in an email dated 15 April 2020. This was picked up by DHSC, who set out a detailed explanation of why I should not be making final decisions. In response, I was quick to set the record straight as to my role and the nature of my recommendations, **[EL3/080 INQ000533129]** stating "*To be clear, I am not signing off any deals from a finance perspective, but giving a recommendation to finance that from my perspective, they should be proceeded with. I am well aware I have no authority to do so, and I thought we were all clear on this point*". In respect of proceeding without QA approval, the email of the same date attached to the email above (i.e. DHSC's Director of Finance explaining the position to HM Treasury) **[EL3/081 INQ000533130]** explains "*whilst the approach to PPE due diligence to date has been successful in reducing risk of stock purchased/delivered being unfit for purpose, the time it is taking to undertake this process means we have triggered a much greater risk on securing supply itself".* It goes on to say, *"I discussed with Emily how we rebalance the risk i.e. take slightly more risk on due diligence to help reduce the risk of losing deals and 'stocking out' on international procurement"* and *"For clarity, we are not prepared to give clinicians any PPE that aren't going to keep them safe – at no point will this be done and we continue to be led by PHE Guidance".*

182. This email relating to rebalancing of risk is relevant to an understanding of the factors I took into account when making a recommendation on a particular deal or offer and how much weight to attribute to each factor.

183. In respect of both PPE and ventilators, value for money was a significant factor in a decision whether to progress an offer. Over the period March, April and May 2020, the price of PPE and ventilators increased substantially compared to the pre-pandemic price. There was extreme pressure to procure more equipment. It was a seller's

market. Although the team often sought to negotiate the price down, the fast-paced nature of the market in that period meant any delay in agreeing price could result in losing the opportunity. There was also an ethical dimension in that people were dying as a result of Covid-19 and, early in the pandemic, ventilating patients was seen as the treatment most likely to succeed in seriously ill patients. There was a view that we shouldn't be putting lives at risk if we could possibly avoid it. This favoured paying higher prices than might otherwise have been considered acceptable.

184. Factors other than price were taken into account. These included whether there were alternatives to the deal, e.g. the likelihood that the Ventilator Challenge was going to produce new devices in time to match the expected peak in demand, and whether there were sources other than China. It became apparent that there were very low quality/specification devices available (for a price), but these would likely have failed the relevant technical checks and so would have been deemed clinically inappropriate.

185. It was paramount that there was assurance as to the ability of the supplier/manufacturer to actually deliver goods that met the clinical and technical specification within the timescales required. There was little value in inflated prices for ventilators or PPE that would not reach the UK for several months.

186. A further factor was the credibility of the offer and of the supplier/manufacturer. Despite the very pressured timescales to agree to deals, due diligence was carried out on unfamiliar companies, including whether the ventilators or PPE actually existed, whether export controls in the country it was located actually allowed delivery, and ensuring there were contractual provisions that provided protection, such as refunds or non-payment should delivery not occur.

187. Consideration of these factors and attributing relevant weight to each was difficult. In some cases, such as the Kau Media example explained above, a different approach to risk was considered appropriate. The facts of a specific offer and the type and amount of equipment, whether ventilators or PPE, often required a bespoke approach. I provide an example from 20 March 2020 of an offer of several thousand ventilators located in China that triggered discussion between me, Chris Stirling, Steve Oldfield, Chris Young and David Williams **[EL3/082 INQ000541342]**. This discussion also emphasises the rapidly changing market in late March 2020 in relation to ventilators.

188. On 15 April 2020, I discussed with DHSC's Finance Director rebalancing of risk on PPE procurement to reduce the risk of losing opportunities to the intense customer competition in the market at that time. He emailed HMT outlining the approach (see paragraph 181). This involved streamlining technical assurance, while at the same

time ensuring that clinicians were always provided with PPE that would keep them safe. It was a move away from application of the broad British technical standard, due to the time this takes, and towards a less specific but faster approach that provides reasonable assurance that the products are suitable for end-users.

189. In respect of PPE, I attach an example of my role in recommending the purchase of an order of gloves **[EL3/083 INQ000533146]**. The email chain dated 15 May 2020 is started by Chris Hall, Deputy Chief Commercial Officer at the Cabinet Office, providing an explanation of:

    a. the basic parameters of the deal – the number of gloves, price, timing;

    b. why the deal is appropriate at this time;

    c. how risks have been mitigated – involvement of the British Embassy in Beijing, legal review of the contractual terms, due diligence on the supplying company, technical assurance of the gloves and the engagement of an inspection company to carry out a factory and product inspection.

190. I then provided the view from the NHS's perspective – whether the product is needed – and my view on the information provided in the offer. I give my recommendation to approve the deal, as does Jonathan Marron (the DHSC SRO for the PPE Cell). The recommendation is sent to David Williams as Accounting Officer at DHSC, who provides his approval alongside reasons for his decision.

191. I provide another email chain, from 15 June 2020, of an offer for 1.3 billion examination gloves **[EL3/084 INQ000541366]**. The email chain begins with the explanation of the offer, including the price and total value of the offer, details of the staged payment approach, other financial information such as taxes, delivery information and the extent to which glovers are needed at that time. There was clarification of the delivery times and whether this coincided with a shortage of gloves and any stockpile. Recommendation was sought from both me and the DHSC SRO, which we gave. The offer was to be sent to the DHSC Accounting Officer for a decision.

Section 7 – Compliance and regulation of contracts

192. This Section 7 relates to compliance of suppliers of ventilators and PPE to contractual provisions and performance of their contracts. It also sets out the extent to which I was involved in decisions on compliance with procurement regulations and regulatory regimes.

193. As detailed in Section 5 above, wherever possible, physical checks of ventilators and PPE bought from abroad were carried out before they were transported to the UK. In some cases, a physical check was not possible, and photographic or video evidence was asked for before progressing the deal **[EL3/085 INQ000541338]**. Once such equipment arrived in the UK and was transported to the relevant warehouse, further checks were undertaken to ensure compliance with specifications and that the equipment was as agreed.

194. There may have been cases where the DHSC supply team were not 100% satisfied that the equipment met all relevant specification and compliance checks, especially if it was not possible to carry out an in-person physical examination, but the pressure to obtain as much equipment as possible meant it was bought and then subject to intensive checks once it arrived. There was, therefore, sometimes a risk involved in agreeing a deal. I would point out, however, that there was a threshold of reasonable satisfaction as to the equipment's compliance with specification and state that needed to be reached before money was transferred. There were many offers that failed to reach this threshold and the equipment was not bought.

195. There were situations where the DHSC procurement teams pursued commercial restitution on the basis that the contracts had not been performed. For example, if order items did not arrive, there was no question that the supplier had to pay us back or, if money had not already been transferred, we simply did not pay. There was no argument from suppliers here. There were some instances with PPE where the wrong item had been shipped to the UK.

196. As another example, the Aeonmed 510 Shangri-La ventilators were procured in mid-March 2020 and received into the warehouse in early April. They were quickly allocated to the Midlands where an urgent need had arisen. Professor Ramani Moonesinghe subsequently received reports about these ventilators not being suitable and on 13 April 2020 she made recommendations to stop procurement and recoup the costs, replace the machines that had been allocated to NHS Trusts and to ensure that any machines in the warehouse were checked thoroughly by a medical engineering team. The ventilators had been found not to be reliable, with some failing basic

engineering testing. Professor Ramani's recommendations were acted on and future orders were cancelled. More detail on this particular issue can be found in the First Statement of Professor Ramani Moonesinghe.

197. In respect of compliance with public procurement principles, decisions had been made prior to my joining the team that direct awards could be made to suppliers of ventilators and PPE without competitive tendering under the emergency situations provisions (Regulation 32 of the Public Contracts Regulations 2015). I was not part of the decision-making on this.

Section 8 – Reflections

198. This Section 8 sets out my reflections on the supply chains, procurement processes and experiences relating to ventilators and PPE. I consider what could be done differently, or what was learned that would be helpful in the event of a future pandemic. I am conscious that whilst some of these will help in a future and similar pandemic, they would not address problems such as raw material shortages or compressed demand.

199. Data systems – I think for reasons of proportionality, there was no national view to understand organisational inventory of PPE, and the pre-pandemic approach to supply chains run by SCCL meant there was no visibility of where items were in the supply chain before they arrived at the warehouses. While the lack of supply chain insight is not usually an issue in non-pandemic times, as there is high assurance that the ordered goods will arrive when expected, it became problematic when the global market overheated and every deal became risky. I would be in favour of government taking steps to ensure that improved oversight of whole supply chains is maintained outside emergency situations, or, at a minimum, that the capacity to rapidly switch on or establish such systems is a codified aspect of an emergency response. This should recognise that manufacturing supply chains involve not just raw materials but also the machinery itself (and the parts for that machinery). Wider capabilities such as modelling and supply chain mobilisation should be reflected in relevant contracts, including the need for regular exercising.

200. Market risk analysis – at the start of the pandemic, the NHS in the UK was wholly dependent on a just-in-time wholesale market structure for PPE, as it is for many other healthcare consumables. The pandemic showed how quickly this market structure can deteriorate. We were fortunate that for other clinical supplies, including medicines, the EU Exit work had already conducted risk analysis so that strategies were available when some of those supplies came under pressure as well. Later in the pandemic, the Cabinet Office commissioned a global market risk analysis to identify any other areas which might be of concern in a pandemic or other emergency. I would encourage the government to continue a focus on managing global supply chain risk so that there are developed solutions to known risks ready to go when the risk emerges, rather than having to develop the risk mitigation strategy under pressure of an already challenging situation. I understand the office of the CCO meets regularly with the Cabinet Office to discuss procurement and supply chains.

201. Onshore manufacturing - at the start of the pandemic, British manufacturing could not produce PPE in volume. The capacity to manufacture Type IIR (fluid resistant surgical masks) and FFP3 masks, aprons, visors and gowns were all established during the pandemic, although certain materials needed to be imported. The UK had a net advantage in that fabric manufacturers located in Scotland had the right equipment, materials and skills to handle the production of the fabric required for clinical quality masks. The Ventilator Challenge indicated that British firms have the capacity and capability to mass produce basic ventilators. Much of this capacity has been stood down in the last two years. My understanding is that the only item that could now be rapidly produced is aprons, given the easy switch from producing bin bags to producing aprons. The learnings, experiences and skills, if not the actual capacity, for successful domestic manufacturing should be retained to create a resilient position in the case of future global supply chain shocks, including when countries impose export bans and prioritise internal distribution of key medical supplies.

202. "Over-supply" – it will be important in any consideration of perceived 'over-supply' of PPE and other items procured during the emergency, to distinguish between the different phases of the pandemic response, and what was possible (and intended) at each stage. By that I mean that in the initial stages, both obtaining stocks at all and the timelines for any supply were so uncertain that it was considered essential to complete deals that were checked to be credible and technically compliant at a reasonable price on items that were needed. As the pandemic progressed and uncertainties persisted, the government directed the PPE Cell to ensure a minimum of four months of supply were available in central stocks before the focus on buying could lessen. This deliberate stockpiling against uncertainty is not the same, in my view, as 'over-supply'.

203. Robust structures – with no previous template on which to rely, the structure and processes of the ventilator and PPE procurement teams were developed at pace. While the ventilator team structure worked well, the PPE team structure needed adjusting in May 2020 to enable involvement of product-based teams, as different elements of PPE equipment are subject to different manufacturing processes, regulatory oversight, made in different markets and need different consideration when procuring and planning.

204. Making the most of existing infrastructure - as I would later do on the vaccination programme, wherever possible and out of necessity, we built on existing structures, teams and expertise, including in the establishment of UK make, as outlined above. In addition, we were lucky to be able to build on the EU Exit infrastructure that had been

set up to reduce supply risk from EU Exit. In particular, the NSDR was an EU Exit response structure that was then able to rapidly establish an emergency response process for PPE shortages. To avoid either dismantling structures that we then find we need in an emergency, or keeping unproductive structures and processes running when they aren't immediately needed at cost to the taxpayer, I would encourage the government to consider this kind of repurposing where structures can be used in different but related ways in day-to-day business and can be built on in an emergency situation. I would also add that the benefit of the EU Exit work was that it was very recent and in corporate memory. This shows the usefulness of emergency preparedness exercises and many of these reflections can be incorporated in these exercises going forward.

205. Getting the right expertise – the pandemic fostered extensive cross-organisational working at a rapid pace. That enabled us to ask, and receive, support from a range of experts, without whom we could not have delivered. For example, in PPE we could not have delivered without support from the British Embassy in Beijing, from legal expertise from the Government Legal Department, from the commercial skills from the Cabinet Office, the technical assurance team from MOD, and the external contractors and consultants, as well as all the NHS and DHSC staff involved. We benefitted from bringing in supply chain expertise and from the Army's 101 Log, who used their expertise from managing logistics in conflict situations to support in running many aspects of the PPE Cell. This is on top of the cross-organisational working with MHRA and HSE and many other organisations mentioned above. Equally, we informed them and a virtuous circle was created. On a personal level, it meant that when I was asked to run the NHS vaccination delivery programme, I had a clear picture of the breadth of government expertise that could be provided and the relationships made provided a critical foundation for the success of the vaccination programme. One of my first actions in the vaccine programme was to ask Steve Gibb to lead on the supply chain for vaccination, and my next was to request support from the Army to run the programme. I was very grateful that the Army decided to send 101 Log again, recognising that speed was of the essence and that the trust built up during PPE would be foundational to rapid development of the team to run vaccination. My advice to the Government is to bear in mind that in the next emergency, it will be equally critical to rapidly find the individuals and teams with the right skills and attitudes.

206. People with relevant skills to lead under pressure – there should be investment in upskilling people to run an operation while simultaneously looking ahead, or at least in training people to set up teams that can do both. Across the UK public sector, there

has been a substantial investment in the professionalisation of commercial skills, for example, over the last 10 years, and in the skills to run major programmes via the IPA's programmes. We need to ensure that we are forecasting the skills we will need to manage ever more complex programmes and those required to deliver such programmes under intense scrutiny and the pressure of an emergency situation. This will include training and support for individuals to manage their career paths to build these skills. The onus is on recognising an individual's potential and providing appropriate training and career progression. This would benefit the NHS every day, not just in a pandemic emergency.

207. One of the things we do benefit from in the NHS is our EPRR framework and standards, with our annual assurance processes. These frameworks and teams are used to dealing with 'incidents' affecting the NHS – floods, winter pressures, terrorist attacks, as well as for preparedness. As part of emergency preparedness, the NHS undertakes 'exercises' to stress-test plans and scenarios (as well as identify the skills that might be required) as described in NHS England's Module 1 Statement.

208. Flexibility in legislation - Regulation 32 of the Public Contracts Regulations 2015 was helpful to enable us to act at pace in securing ventilator and PPE offers. In my view, thought should be given to guidance for public sector purchasing authorities on decision making in inflationary/price surge situations.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court 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: 7 February 2025