MILLS & REEVE

Witness Name: Paul Barnaby Webster

Module 5 Statement No: 1

Exhibits: 13

Dated: 27 June 2024

In relation to the issues raised by the Rule 9 Request dated 22 November 2023 in connection with module 5, I, PAUL BARNABY WEBSTER, will say as follows:

1 My role in assisting the Inquiry on behalf of Supply Chain Coordination Limited ("SCCL")

1.1 I am the Executive Director of Governance and Legal as well as the Company Secretary of SCCL.

1.2 I am part of the team responsible for the management of SCCL and the wider NHS Supply Chain and ensuring that it is managed appropriately, being wholly funded by public money. I also perform the role of SCCL's in-house counsel.

1.3 I have been directly employed by SCCL since October 2022. Before this date I was seconded to SCCL from the Government Commercial Organisation starting from the incorporation of SCCL in July 2017. Before SCCL's incorporation, I was part of the Department of Health and Social Care ("DHSC") team which set up the new operating model for the management of the NHS's purchasing and logistics function as far as it applied to medical devices and clinical consumables (as part of which SCCL was incorporated).

1.4 I have been asked to provide this statement, on behalf of SCCL, to assist Module 5 of the Inquiry which is considering the 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.

1.5 This is my second statement to the Inquiry. On 7 December 2023 I provided a statement for Module 3.

1.6 The information in this statement is either information that is directly within my knowledge or, where that is not the case, I have consulted with colleagues

who remain with the business and the content of the statement is therefore corporate knowledge.

2 Key Figures and Decision Makers

2.1 SCCL is managed by an executive team made up of a series of directors each responsible for a specific area of the business. The executive team has had a number of changes in personnel since the incorporation of the company. At the start of the pandemic the executive team was as set out in slide 2 of the organogram at PBW01 [INQ000425387]. The majority of those individuals (highlighted in red) have subsequently left the business.

2.2 At the start of the pandemic the following individuals had specific responsibility for the areas of the business which are covered by this module:

2.2.1 Jin Sahota-CEO. As CEO he was responsible for the overall management of the business and accountable to the SCCL Board of directors and through them to the Secretary of State for Health & Social Care.

2.2.2 Alan Wain-Chief Operating Officer. As COO, Mr Wain was responsible for the day-to-day operation of the business.

2.2.3 Chris Holmes-Director of Supply Chain. Mr Holmes was specifically responsible for both the procurement and logistics element of NHS Supply Chain.

2.2.4 Joanne Gander-Director of Clinical and Product Assurance. Ms Gander was responsible for ensuring that the appropriate assurance processes had been followed in relation to products.

2.2.5 Colin McCready-Chief Financial Officer as CFO Mr McCready was responsible for all financial aspects of the business.

3 Overview of SCCL

3.1 From 2006 until 2018, DHSC (through the NHS Business Services Authority ("the BSA")) contracted with DHL to manage what is known as the NHS Supply Chain i.e. a centralised procurement entity that provides clinical consumables and non-pharmaceutical products to NHS Trusts utilising the greater buying power gained

from buying products in larger quantities to get better pricing than that which can be achieved by individual entities. NHS Supply Chain operates effectively as a known brand within the NHS irrespective of its constituent parts. This contract required DHL to provide an end-to-end service including the procurement, warehousing and shipping of products together with ancillary services such as invoicing, customer services and the management of the relevant IT systems.

3.2 DHSC developed a new model known as the Future Operating Model ("FOM") to replace the DHL contract on its expiry in 2018. This involved the disaggregation of the previous model into its constituent parts with separate contracts for the procurement of products and the provision of logistics and IT services. The intention was for there to be a management function of the model, contract managing the entire arrangement. SCCL was created to act as that management function. The intention of the FOM was to increase the market share of NHS Supply Chain from approximately 36% under DHL to 80% and, in doing so, deliver £2.4 billion of savings to NHS Trusts.

3.3 SCCL provides oversight and operational management for NHS Supply Chain and its service providers and is the legal entity through which NHS Supply Chain undertakes its procurement services and transacts with customers and suppliers. It is important for the Inquiry to understand that NHS Supply Chain is not the same as the supply chain to the NHS and I will do my best to make that distinction throughout my statement. SCCL can answer questions about NHS Supply Chain but cannot answer questions about the various other supply chains to the NHS more generally. The rationale for NHS Supply Chain is set out in paragraph 3.1 above but it covers only a proportion of the products purchased by the NHS for which a number of other supply chains exist.

3.4 SCCL (a company limited by shares) was created on 25 July 2017 by DHSC. It was initially wholly owned by the Secretary of State for Health & Social Care who provided direction to the company through an appointed director on the SCCL Board. Ownership was subsequently transferred to NHS England/Improvement ("NHSE") on 1 October 2021. SCCL is a separate legal entity from NHSE.

3.5 SCCL is directly responsible to its shareholder, NHSE, although the Secretary of State retains some overall level of control through what is known as the Act of Entrustment. At PBW11 [INQ000492082] I attach a copy of the Service

Agreement between SCCL and NHSE which details the services which SCCL is required to provide and is the contractual mechanism through which SCCL is funded. The Service Agreement provides that it will terminate with immediate effect if the Secretary of State's original Act of Entrustment is revoked.

3.6 NHSE have a shareholder on the Board of SCCL whose approval is required for any decision. There are also quarterly accountability meetings chaired by NHSE's Chief Commercial Officer which reviews delivery against the requirements of the Service Agreement. Our accounts are published on an annual basis as required by the Companies Act and our business plan is approved annually by both our Board and NHSE.

3.7 SCCL is managed by an executive team which answers to a board of directors which, at the start of the pandemic, included an independent Chair, four non-executive directors, the CEO and CFO of SCCL and three "stakeholder" directors, one from DHSC and two from NHSE appointed in expectation of the transfer of ownership (referred to at 3.4 above). Whilst the company is a private sector entity, it remains subject to the control of its shareholder with a number of reserved matters that require the approval of the shareholder, for example, to enter into significant contracts or major items of expenditure. In that way, DHSC and NHSE can demonstrate that there is an appropriate level of scrutiny of the public money that funds SCCL and NHS Supply Chain which it manages.

3.8 In June 2017 DHSC introduced the FOM arising from the Carter Review of June 2015 into efficiency in hospitals. The aim of the FOM was to move the majority of non-pharmaceutical procurement to one centralised body namely SCCL. At the time of the FOM and to this day, there are a number of different routes for procurement and supply to the NHS. The FOM was intended to encourage more centralised procurement by, for example, leveraging greater purchasing power in order to generate savings for the NHS as a whole.

3.9 SCCL began operating in April 2018 when the FOM was implemented. SCCL was set up as the management function of NHS Supply Chain to facilitate the FOM so was created for the purpose of the FOM. At PBW02 (INQ000347820) I attach a diagram showing an outline of how the FOM was constructed. Under the FOM 11 'Category Towers' were established each with a Category Tower Service Provider ("CTSP") responsible for the procurement of all products that come within that category or categories. Some CTSPs covered more than one

Category Tower. In addition to the Category Towers dealing with procurement of products there were a further two contracts dealing with Logistics and IT. Each CTSP was responsible for developing and implementing a specific strategy for each of its relevant category of products. I have set out more detail about the CTSPs and how they operated at paragraph 5 below.

3.10 Historically, (i.e. at the start of the pandemic) NHS Supply Chain provided clinical consumables and non-pharmaceutical products only to NHS Trusts and Foundation Trusts. These Trusts were Acute, Mental Health, Community and Ambulance Trusts in England. NHS Supply Chain does not normally supply GPs, community care organisations, care homes, social care or dentists. This continued to be the case once SCCL began operation in April 2019 but changed during the pandemic.

3.11 In addition, NHS Supply Chain was set up to manage the supply of these products in England only. From time to time, SCCL has undertaken broadly the same work, supplying the same products to the devolved heath systems in Wales and Scotland but this was a very small percentage of our activity. We did not supply services to Northern Ireland.

3.12 SCCL is purely a transacting rather than a decision-making body. Prior to the pandemic it took instruction from DHSC/Public Health England ("PHE") and NHSE. During the pandemic it also received instructions at different times from other Government Departments and the Army.

3.13 SCCL received instructions through a variety of different means including face-to-face meetings, calls or emails. Prior to the pandemic, regular meetings were held with the DHSC and PHE and instructions would often have been given in those sessions. In addition, regular emails between the parties would include further instructions. SCCL had a close working relationship with all the governmental entities with which it worked so there would be a constant process of communications going on between the parties.

3.14 As the pandemic was declared everything was very fast moving sometimes on a minute-by-minute basis and calls and messages would have been exchanged frequently. As I have explained below regular calls were established 3 times a day in order to deal with issues arising during the course of the day and that was an opportunity to receive instructions and give

feedback. Significant instructions would be given by letter from the Secretary of State (see for example, PBW05 INQ000425391) but otherwise there would have been a near constant flow of instructions and information. It would be extremely difficult to try to find any documents which track these less formal exchanges especially now that most of the key individuals have left the business. However, to the extent that I cannot identify copies of key instruction documents (if any) coming from the DHSC/PHE or NHSE it should be possible to identify these from the disclosure these parties are giving the Inquiry.

3.15 SCCL enters into contracts for goods and services with various suppliers of the relevant products and services and makes payment for goods and services pursuant to the terms of those contracts. SCCL then sells those products to its NHS customers at the price at which it purchases them. As regards contracting, SCCL is a contracting party for the provision of goods and services and all such goods and services are purchased in the name of SCCL before being sold on to the relevant customer. Further detail of how this contract activity is undertaken is set out below.

3.16 What I have described above was SCCL's 'business as usual' ("BAU") activity prior to the pandemic. As I will explain elsewhere in this statement, during the Covid-19 pandemic SCCL continued its BAU activity except in relation to the procurement of PPE responsibility for which passed to DHSC. SCCL only resumed responsibility for the procurement of PPE from 1 April 2022.

Funding

3.17 SCCL is funded by means of a Service Agreement referred to in paragraph 3.5 above (PBW11 INQ000492082) (initially with the DHSC but novated to NHSE when ownership transferred) which sets out its core obligations in relation to the management of NHS Supply Chain. In return for delivering those services, SCCL receives a service fee in 12 equal monthly instalments which are applied to fund its operating costs including the service providers under the FOM referred to above.

3.18 This service fee is agreed annually with NHSE in the usual public sector budgeting round and so changes in April of each year. This supports SCCL's core business, and the principle of this funding is unchanged. The service fee did not change as a result of the pandemic but additional funds were provided

to us in the form of the Covid response loan referred to at paragraph 3.20 below and the DHSC reimbursed SCCL for the additional costs caused by the pandemic, for example the additional logistics requirements which I will deal with in further detail below.

3.19 In addition to the allocated budget, SCCL also has the benefit of a working capital loan from DHSC. Interest at full commercial rates is charged on this loan and the purpose of the loan is to provide capital to fund SCCL's procurement activity.

3.20 In response to Covid-19, DHSC also made a 'pandemic response loan' to SCCL which was interest free. This facility enabled SCCL to carry out procurement activities during Covid-19 where global prices were higher and often goods had to be paid for in advance. Effectively it supplemented the working capital requirement to support purchasing in response to the Covid-19 pandemic.

3.21 The loan was agreed with DHSC as the most appropriate form for providing the necessary funding for products as and when it was required. This was initially set at a figure of £2 billion but increased over time to £5.5 billion (all of which has now been repaid). The loan ensured that SCCL was always able to pay for the required volumes of products, particularly PPE.

4 Procurement Activity

4.1 SCCL is a transactional body. Under the FOM, procurement was undertaken by the CTSPs acting as agent for SCCL so transactions are entered into in the name of SCCL. The CTSPs would conduct procurement in accordance with the terms of the Public Contracts Regulations 2015 (as amended from time to time) ("the PCR") as agents for SCCL.

4.2 At all times, both prior to and during the pandemic, SCCL adhered to the PCR, relevant Procurement Policy Notes ("PPNs") issued by Cabinet Office and Crown Commercial Service from time to time and the standard Selection Questionnaire in the template provided by Cabinet Office. These are statutory and published documents which apply to all 'contracting authorities' within the definition of the PCR.

4.3 SCCL does not (and does not need to) advise government departments (or any other entity) on how to conduct procurement because public procurement is contained within the statutory framework of the PCR as supplemented from time to time by PPNs and other published documents. It should always be adhered to by any public body within the scope of the PCR.

4.4 Accordingly, the policy in place for best practice in procurement and appropriate due diligence on suppliers was to adhere to both legal and government best practice through complying with the PCR and the relevant PPNs (as supplemented by case law from the courts). There was no need to share best practice because the PCR applies to all contracting authorities including the departments of HM Government and there is no 'single source' written best practice. SCCL would follow best practice by complying with the law and published guidance.

4.5 As I have said, all procurement carried out by SCCL whether prior to the pandemic by the CTSPs, during the pandemic or after the pandemic is in accordance with the PCR and the contracts with the CTSPs required the Towers to operate in accordance with all applicable laws and regulations (which would include the PCR) whilst conducting procurement activity as agent for SCCL (see paragraph 5.8 for more details on this). Accordingly, any written policy or guidance to staff regarding best procurement practice and the principles of the law around procurement would have been the responsibility of the CTSPs.

4.6 To assist the Inquiry, I have described below various methods of procurement which are permitted by the PCR because some of the terminology can be confusing and there is a need for clarity in understanding SCCL's procurement activity.

Methods of Procurement

4.7 Direct awards, framework agreements, call offs and open competition are all permitted under the PCR:

4.7.1 A framework agreement is procured under Regulation 33 of the PCR by way of open competition. Every supplier appointed to a framework has passed a set of requirements set out in the tender

documents including as to, for example, financial security, appropriate technical assurance of the product and price.

4.7.2 A framework agreement effectively creates a pool of known suppliers who have met certain requirements.

4.7.3 Once established the framework agreement can be accessed by any public authority permitted to use the framework when it was established. In order to 'call off' from a framework an authority can either run what is known as a 'mini-competition' between some or all of the suppliers on that framework or, if permitted by the terms of the framework agreement, may make a 'direct award' to a particular supplier. In either case, the award is to a supplier already identified and pre-selected for a place on the framework by 'open competition' so it is important to be clear that if direct award under an existing framework agreement is used then that award is still to a known supplier who has already been through a competitive procurement process. I want to emphasise this because it is confusing to reference 'direct award' without understanding the way framework agreements work and it is important not to conflate 'direct award' with an absence of competition.

4.7.4 In addition to framework agreements, the PCR allows for other forms of 'open competition' by various means. It also allows, in certain circumstances, for 'direct award' to a particular supplier under Regulation 32 of the PCR. This type of 'direct award' may be made without any form of open competition.

4.7.5 The reason for setting this out is to emphasise that framework agreements, open competition and direct award are not mutually exclusive. In particular if a framework agreement is established by open competition it can then allow for further competition or for direct award.

SCCL Procurement

4.8 The vast majority of SCCL's procurement is through the creation and subsequent call off from framework agreements. The framework agreements are usually in place for a period of four years (typically for an initial two years

with an option to extend for a further two). The only exception to procurement through frameworks is in very limited circumstances where an award direct to a supplier is permitted under the PCR for example, in an emergency or for new innovative products not on a framework. There is a constant cycle of tenders. SCCL currently manages some 138 framework agreements:

4.8.1 Transaction product categories (those products which we stock in our warehouses, often the more commonly used consumables):

(i) 88 frameworks

(ii) 1814 suppliers

(iii) Current £2.28 bn spend per annum.

4.8.2 Direct product and service categories (where SCCL procures the framework but Trusts contract direct with the supplier)

(i) 30 frameworks

(ii) 788 suppliers

(iii) Current £1.12 bn spend per annum;

4.9 In total 2602 suppliers are currently involved and this is constantly being updated as frameworks are renewed and re-tendered.

4.10 Throughout the pandemic, SCCL procurement continued through framework agreements and I will explain in more detail what that involved in later paragraphs.

4.11 Under the FOM, the 11 Category Towers were created to manage the procurement of different products (see paragraph 3.9 above). The procurement activity on behalf of SCCL was therefore carried out by the relevant CTSPs, which are separate legal entities. As far as I am aware, apart from the 'normal' recruitment of staff to fill vacancies as required none of the CTSPs were supported with additional staff during the pandemic. The training of staff on the PCR would have been the responsibility of the CTSPs and is not something I would be able to comment on.

4.12 Early in the pandemic some of the CTSPs (Towers 2, 8 and 10) 'loaned' some staff to the PPE Cell set up by Cabinet Office/DHSC. I will explain more about this below.

4.13 I have been asked to comment on the extent to which SCCL made use of direct award without open competition during the pandemic. In response to that question, I need to reiterate what I have said at paragraph 4.7 above about the terminology around different types of procurement activity. There is a distinction between a direct award under Regulation 32 of the PCR and a direct award that is permitted under the terms of a framework agreement established under Regulation 33. For ease of reference, I have referred to these below as a "**Regulation 32 Direct Award**" and a "**Framework Direct Award**".

4.14 A framework agreement will always be established by way of an open procurement process under the PCR. Once established it may be permissible under the terms of the framework agreement to appoint suppliers either directly (a Framework Direct Award) or by a process of a further 'mini-competition'. If a Framework Direct Award is made from the pool of suppliers already on the framework agreement then this has followed from a process of 'open procurement' which led to the establishment of the framework agreement. In contrast, a Regulation 32 Direct Award would not typically involve any form of competition.

4.15 Given that the procurement activity for consumables, prior to the pandemic was carried out by the CTSPs I cannot say for certain that there were no Framework Direct Awards permitted by the terms of a framework agreement prior to the pandemic indeed, as explained above, I believe that on a very limited number of occasions, innovative products may have been purchased this way although it would not be our standard approach. There were no Regulation 32 Direct Awards.

4.16 However, during the pandemic SCCL did make use of PPN 01/2020 which permitted Regulation 32 Direct Awards to suppliers. However, such Regulation 32 Direct Awards were only made to suppliers who were already known to SCCL. They were not new suppliers. They were to suppliers who were already on a framework agreement (and had therefore satisfied the requirements for that framework following an open competition) but who may not have previously supplied the item ordered. For example, if a supplier was on a framework

agreement for the supply of facemasks but not for the supply of gloves then a Regulation 32 Direct Award might be made to that supplier for gloves. Such Regulation Direct Awards were only made during the period of the validity of PPN 01/2020.

4.17 NHS Supply Chain did not operate outside of the usual procurement processes. It only placed orders with suppliers with whom it already had a relationship whether under a framework agreement, a Framework Direct Award or a Regulation 32 Direct Award. Questions of conflict of interest were addressed at the time the framework agreement was tendered through open competition by the CTSPs.

5 Contracting Out Procurement Functions

5.1 As I have described above, under the FOM, the procurement of healthcare equipment and supplies was split into 11 Category Towers each managed by a CTSP. The CTSPs were responsible for the procurement of goods within the scope of each Tower on behalf of and subject to overall oversight by SCCL. Each of these CTSPs was a separate legal entity with their own corporate governance and structure. Each CTSP was appointed following a competitive procurement process run by DHSC.

5.2 At PBW03 [INQ000425389] I attach a copy of the contract with Tower 2. The contracts for each of the Towers were substantially in the same form as this other than for details such as the specification and commercially sensitive matters such as price. These contracts were originally between BSA and the CTSP but were novated to SCCL once the company was fully operational.

5.3 The contractual arrangements with the CTSPs were created as part of the FOM and continued throughout the pandemic. However, from March 2020 to April 2022 responsibility for the procurement of PPE was taken over by a dedicated PPE team which sat within DHSC and over which DHSC had ultimate management and control.

5.4 Under the FOM, 11 Category Towers were established to procure items falling within the scope of each Category Tower. I attach at PBW04 [INQ000425390] an FAQ document which details who the CTSPs are and what category of goods fell within each Tower.

5.5 The following bodies were the CTSPs for medical products and services:

5.5.1 Towers 1 and 3-DHL Life Sciences and Healthcare UK;

5.5.2 Towers 2, 4 and 5-Collaborative Procurement Partnership LLP;

5.5.3 Tower 6-Health Solutions Team Ltd;

5.5.4 Tower 7-DHL Life Sciences Healthcare UK; and

5.5.5 Tower 8-Akeso & Company.

5.6 The remaining Towers are not relevant to the matters covered by the Inquiry as they cover Non-Medical Services for example food, stationery and cleaning products.

5.7 The CTSPs would undertake clinical evaluation of products and run the procurement of those products on behalf (as agent) of SCCL and NHS Supply Chain. Those procurements would be undertaken under the PCR.

5.8 The overall aims and objectives of the CTSPs under their contract was to "*implement a Category Tower and associated Category Strategies that will deliver the savings, benefits and service levels* [set out in the Tender and Contract]. *In doing so, the Category Tower Provider must undertake high quality engagement with stakeholders and with all other areas of the Future Operating Model. The Category Tower Provider must ensure that all contracts are compliant with relevant procurement legislation ensuring the continuity of high quality products and services to Customers."* (see page 98 of PBW3).

5.9 CTSPs were required to implement *"Category Strategies, compliant contracts, customer engagement plans, product supplier performance and engagement plans, product stocking strategies, product switching plans and market and sales strategies to deliver* [agreed savings]".

5.10 CTSPs were remunerated under their contracts on the basis of savings achieved.

5.11 The 'towers' system is still in place for the purchase of, predominantly, non-medical products. These contracts were reprocured at the end of their initial contract terms.

5.12 However, as part of a programme of continuous improvement and lessons learned, SCCL has recently consolidated medical, clinical and consumables into a single category and brought the procurement in-house following the expiry of those Tower contracts. In so far as this concerns this Module of the Inquiry this means that the procurement of items within the description of PPE is now undertaken in-house by SCCL.

5.13 Our reason for doing this was to simplify the operating model implemented through the FOM with the intention of achieving greater levels of efficiency and effectiveness through a more consistent approach and greater economies of scale. By creating single category management vehicles we have the ability to flex our resources to align to priorities as they change.

Logistics Category Tower

5.14 Unipart Logistics were appointed as the logistics provider to NHS Supply Chain following a competitive tender process in August 2018. As the logistics provider under the FOM, Unipart managed the storage, warehousing and distribution of healthcare products ordered from NHS Supply Chain. The Unipart contract runs to some 524 pages plus a number of substantial additional schedules amounting to a further 500 pages. Much of the contracts and schedules comprise standard contractual terms but also the whole of Unipart's original tender (including pricing) and in the schedules a number of Heads of Terms relating to additional warehousing space. Some of that information is commercially confidential.

5.15 Unipart subcontracted part of the logistics service that relates to the delivery of, principally, continence products direct to patients at their home to Movianto Limited ("Movianto"). This element of the logistics service is not relevant to this module. SCCL retained overall management of the logistics operation.

5.16 In relation to SCCL's BAU activity during the pandemic, Unipart continued to be the logistics provider for distribution including for the home deliveries referred to at paragraph 5.15.

5.17 During the pandemic response, Unipart entered into further sub-contracts for logistics support in relation to the storage and distribution of products acquired by the PPE team under the direction of DHSC. As part of the establishment of a separate supply chain for PPE Clipper Logistics plc ("Clipper") (now GXO

Logistics but for ease of reference I will continue to refer to them as Clipper) took over responsibility for distribution of PPE. The easiest way to facilitate this was to establish a sub-contracting arrangement between Unipart, as the logistics provider to NHS Supply Chain, and Clipper. SCCL retained overall management responsibility. The sub-contracts with Clipper form part of the contract schedules I refer to at 5.14 above and can be made available to the Inquiry if required.

5.18 Finally, and for completeness, Movianto was also responsible for the logistics operation around the distribution of the PIPP stockpile. This was under an entirely separate contractual arrangement to that referred to in paragraph 5.15 above and which I have described in detail at paragraph 17 below.

IT Provider

5.19 DXC Technology are the IT provider to SCCL/NHS Supply Chain appointed following a competitive tender process.

6 Total Spend Figures

6.1 SCCL only took over responsibility for management of NHS Supply Chain in 2018. We are unable to provide data before the financial year 2018/2019.

6.2 I am attaching at PBW07 [INQ000438168] 2 charts showing (a) NHS Supply Chain spend on product and (b) the spend on PPE.

6.3 The chart marked PBW 07 Figure 1 [INQ000438168] sets out the cost (inclusive of VAT) for all purchase orders for those products that are not classified as PPE for each financial year (the pink blocks measured against the left hand axis) as well as setting out the number of individual products ordered (shown by the blue line against the number on the right hand axis). The information for the third financial year does not reflect an exact like for like comparison with the first year as the third year includes an increase in activity after the pandemic coupled with an increase in market share in certain categories as well as the inclusion of products such as wipes demand for which significantly increased but which are not caught within the definition of PPE.

6.4 The second chart in PBW 07 Figure 1 [INQ000438168] then shows the information for the same periods with PPE added in. To see either the value of PPE purchased or the number of products purchased subtract the relevant

figure in the first chart from the equivalent figure in the second chart. For example, the PPE spend in 2019/2020 would be £103,532,961 (£2,086,983,090 minus £1,983,450,129).

6.5 The final illustration in PBW 07 Figure 2 [INQ000438168] shows the value of invoices for PPE (the first chart) and products for the Nightingale units (the second chart) submitted by SCCL for payment by DHSC. This reflects purchases made by SCCL on behalf of DHSC.

6.6 I intend the charts referred to above to be helpful summaries of the cost to NHS Supply Chain of responding to the pandemic.

6.7 In dealing with total spend I have been asked whether SCCL provided assistance to DHSC in benchmarking prices for PPE. SCCL did provide details of existing pricing for PPE. All of that pricing information would have represented the pre-pandemic prices for those items which came to be described as PPE. These prices would have been fixed following a process of open competition amongst suppliers for a place on the relevant framework.

6.8 Many of the suppliers of PPE were international but there would have been no international comparison as such as the prices quoted would have been competitive within the UK market so international comparison would not have been relevant.

6.9 In any event, since the only pricing information SCCL had access to was pre-pandemic it was almost immediately irrelevant as the huge global demand for items of PPE meant that demand hugely exceeded supply which rendered historic price information irrelevant. Global demand meant the suppliers were in a position to ask almost any price they wanted.

7 SCCL and NHS Supply Chain

7.1 As I explained earlier, SCCL is the management function of NHS Supply Chain. It was set up to service approximately 240 NHS Trusts and Foundation Trusts in England (in multiple locations and with multiple delivery points at those locations) in respect of a catalogue of BAU products. These were bulk deliveries on large lorries.

7.2 Even under the FOM it was never anticipated that NHS Supply Chain would be the sole supply chain for the NHS in England for those products which it

purchases. The aim of the FOM was to increase the market share of NHS Supply Chain so that the purchasing power of the NHS could be leveraged better but there remain alternative supply chains to the NHS both for those products which we purchase and those that we do not. This was the case before, during and after the Covid-19 pandemic. I can only speak about these supply chains in very general terms, and I can also only comment on the supply chain to the NHS bodies which NHS Supply Chain supplies namely NHS Trusts.

7.3 As legally autonomous organisations, NHS Trusts are free to procure healthcare equipment and supplies wherever and from whomever they choose. Most NHS Trusts will have their own procurement teams and some will also be members of a purchasing consortium again running their own procurements. Some will purchase from other framework providers or direct from suppliers or distributors outside of NHS Supply Chain. This was the case prior to the start of the pandemic and continues to be the case even now.

7.4 Of those Trusts which did use SCCL not all customers buy the same amount. Some buy almost nothing and obtain deliveries from elsewhere whilst some buy almost everything via SCCL. Irrespective of volumes purchased, our customer team would be in regular contact with Trusts to discuss, for example, their requirements, savings opportunities and information about specific products. Those discussions increased as concern about Covid-19 grew.

7.5 When the FOM was introduced NHS Supply Chain accounted for approximately 38% of the market for relevant products, this has now risen to more than 60% but whilst all NHS Trusts purchase some products from NHS Supply Chain there is (and always was) a significant difference between NHS Trusts in the percentage of products that they buy through this route.

7.6 Prior to the pandemic, under BAU, NHS Trusts could choose to purchase hospital consumables from NHS Supply Chain. If they wished to purchase then they would consult a catalogue of available products, place an order and the order would then be picked, packed and delivered through SCCL's logistics operation. The items in SCCL's catalogue were available through the procurement of framework agreements with suppliers through which orders would be placed and stock created.

7.7 In relation to pricing, the model of the FOM is predicated on the basis that economies of scale mean that SCCL's prices are cheaper than those that NHS bodies can obtain when purchasing on their own or as part of a smaller group. Generally, our experience is that this is the case and that economies of scale have driven lower prices to the NHS. However, as with any market place, cheaper prices can sometimes be available where a supplier wishes to increase its market share by selling direct to customers.

7.8 Maximum prices are fixed as part of the procurement for the framework. However, one advantage of the use of framework agreements is that they offer the opportunity to secure lower prices as part of the 'call off' from that framework agreement so there was always flexibility on pricing without exceeding the maximum price.

7.9 The FOM was established on the basis of "buy price equals sell price". That means that the price SCCL is charged by a supplier is the price that SCCL charges to its NHS Trust customers. SCCL operates on the basis that it is not expected to generate a profit.

7.10 I have no knowledge of how smaller care homes, GPs or dentists go about procuring healthcare supplies and equipment.

7.11 As the management function for NHS Supply Chain SCCL managed the sourcing delivery and supply of healthcare products, services and food for NHS Trusts across England. Both before and during the Covid-19 pandemic this also involved procuring (apart from PPE during the pandemic), storing and distributing healthcare products through a warehousing and logistics operation.

7.12 During the pandemic, SCCL remained the management function for NHS Supply Chain. However, in one important respect, NHS Supply Chain's role in relation to the procurement and distribution of products known as PPE did change during the pandemic and I will describe this in more detail below (at paragraph 11).

7.13 PPE formed only a very small proportion of NHS Supply Chain's procurement activity before the start of the pandemic. The vast majority of this activity came from other products and we continued to provide those products throughout the pandemic albeit not in the same volumes as previously (as the nature of

procedures carried out by NHS Trusts changed from what would be considered to be usual operations).

7.14 SCCL also continued to be responsible for the logistics element of NHS Supply Chain but also added additional logistics facilities and delivery models to deal with the increased demand for PPE. Again, I will deal with this in more detail later in my statement.

Demand

7.15 At the start of the pandemic SCCL had some 600,000 or so individual items in its catalogue. It would be huge task to interrogate the data for all of those items especially where most of the information would be irrelevant so I have not therefore attempted to show what the increase in demand was for everything in our catalogue however, the charts referred to in paragraph 6 give some idea of this.

7.16 In general terms, in relation to the items and customers which NHS Supply Chain supplied under its BAU model, the start of the pandemic witnessed a significant increase in demand for the products in its catalogue both PPE and other clinical consumables. This was driven by stock-piling by NHS Trusts at the start of the pandemic.

7.17 It is particularly hard to track an increase in demand for "PPE", because this was not a defined category of goods prior to the pandemic in large because demand for the products now classified as PPE was at a comparatively low level. In the early days of the pandemic, however, demand for items which come within the description of PPE began to surge and threatened to overwhelm SCCL's BAU activity. Accordingly, in late March 2020 DHSC established a PPE Cell which dealt with the requirements for PPE separately from the remainder of SCCL's business.

7.18 SCCL continued to buy everything other than PPE required by NHS Trust customers but reflecting their changing work patterns. For example, demand for procedure packs (ie pre-packed surgical procedure kits containing a specified number and type of particular items such as drapes and instruments) reduced significantly because routine surgical procedures were no longer taking place and these packs were therefore not required.

7.19 Obviously, the comments above are headline observations. The charts included at PBW 07 [INQ000438168] provide an indication of the general increase in demand during the pandemic.

7.20 I also attach at PBW08 [INQ000438169] a further set of charts which show the demand for specific types of products with the classification of PPE which helps to illustrate what demand looked like. In relation to these documents it is important to understand the following:

7.20.1 Demand is shown by financial year 2019/2020, 2020/2021 and 2021/2022 where the first time period on the time axis (P202001) refers to **April 2019** and then follows sequentially so that (for example) March 2020 is shown as P202012 as the months relate to the financial year and not the calendar year.

7.20.2 The graphs are based on orders placed to suppliers on SCCL's framework agreements so it will not include new suppliers of PPE nor those which were in the High Priority or VIP Lane;

7.20.3 The figures behind the graphs are based on quantities received so there will be a lag between when they were ordered and when they were actually received. This might explain why the peaks in the data are not always where you might expect them to be given the chronology of the pandemic; and

7.20.4 Although many of the graphs show quite significant peaks quite late in the pandemic the key point is the increase from 2020/02 (April 2019) and 2020/12 and 2021/01 which are the months representing the start of the pandemic. For example, fit test kits show almost no volume between April 2019 (202001) and March 2020 (202012) but volumes pick up significantly from April 2020 (2021/01) onwards.

7.21 It is important to recognise that SCCL can show the increase in demand in relation to the products it supplies and the customers it supplies to at a specific point in time, but this will not give the complete picture of the increase in demand across the NHS as a whole. As I have stressed, NHS Supply Chain was not the only source of supply to the NHS as a whole so it will not be possible to give a single view of demand across the NHS and during the pandemic we had customers buying from us that would not normally purchase

through the NHS Supply Chain so a like for like comparison for specific periods is not possible.

7.22 PBW08 [INQ000438169] above gives an idea of the increase in demand for each of the products within the definition of PPE adopted by the Inquiry subject to the limitations on the data which I have set out above.

7.23 Trying to ascertain the products, other than items of PPE, which experienced the largest increase in demand would be a huge undertaking given that there are 600,000 or so individual items in our catalogue. Attempting to ascertain which of these experienced the largest increases in demand is likely to produce mountains of data which is largely irrelevant to the scope of the Inquiry. In any event, because SCCL was not the sole source of supply to the NHS it has no data which will show the demand picture for the NHS as a whole. Moreover, SCCL did not manage the supply and demand for items of PPE once the PPE Cell was established in later March 2020. Those demand signals were coming from the PPE Cell.

7.24 This Module relates to key equipment and supplies. I have provided the charts to show the rise and fall for demand for items of PPE at PBW08 [INQ000438169]. If the Inquiry has any queries about other specific items within the scope of Module 5 then I would be happy to provide that data for those items if possible but attempting to identify the increase in demand across our whole range of products would be a huge task.

7.25 From early 2020 SCCL started to experience Trusts significantly increasing their orders in large part due to the early effect of Covid-19 in China. This was for all product lines not just PPE. This was comparable to what was happening in supermarkets, as effectively Trusts were starting to stockpile too. It is important to understand that this stockpiling was not just for PPE and healthcare products but for many different items, and the demand included non-essential lines such as a 780% increase in demand for Penguin biscuits as an example. SCCL was also receiving orders from Trusts which had never ordered items or particular lines of items through it before as they struggled to source products through their normal routes.

7.26 A standard logistics response to a big increase in demand (particularly where supply levels might be impacted) is to contact customers and seek to

understand why they are ordering quantities greater than normal and with their agreement cancel down orders to a lower level. Typically, in order to protect stock levels SCCL would implement some demand control/rationing if possible. This would be similar to supermarkets limiting customers to the number of (for example) toilet rolls which they could purchase which was witnessed early on in the pandemic.

7.27 On 31 January 2020 SCCL agreed with DHSC that due to an upsurge in ordering, SCCL would "*monitor and manage demand through…Customer Services and Inventory teams so that any unusual demand patterns are checked and questioned to allow us to try and manage demand and stock levels without causing panic.*"

7.28 SCCL worked in partnership with the DHSC Emergency Preparedness, Resilience and Response team ("EPRR") who triaged PPE requests from Trusts to understand demand urgency and SCCL allocated stock according to EPRR's instructions. Any other product categories were rationed by agreement with NHSE, taking average demand and applying to all Trusts. Since the pandemic, demand controls are now communicated via the NHSSC website https://www.supplychain.nhs.uk/resilience/demand-management/

7.29 Important Customer Notices (ICNs) were published on our website for affected products. The text of these were agreed with NHSE before publication. In addition, , a daily webinar commenced on 16 March 2020 advising customers of the latest situation. The daily webinar became a twice weekly session in April 2020 once PPE purchasing moved to the PPE Cell.

7.30 On 3 February 2020 Joanne Morrison, Head of Public Affairs & PR at SCCL contacted DHSC to approve the text of a message on our website regarding the management of "Wuhan novel coronavirus". The text of the message read "*To help NHS Supply Chain plan and monitor its stock levels please can you advise us with as much notice as possible of your product requirements through contacting your customer services team who will provide you with support. Working closely with DHSC, NHSE/I, we have identified key product lines outlined in PHE's guidance and carefully monitoring our stock levels and Trust ordering levels in line with this guidance. Many of these lines are stock piled and available to flow into the system. Exceptionally large orders or unplanned stock piling is a risk to general service levels, therefore we many need to*

manage any adverse ordering patterns from individual organisations. Your co-operation is essential to helping us managing our stock levels. All organisations are working together to ensure that business continuity is maintained. We are also checking all products that have China as country of origin to ensure that these stocks are still flowing. We will also look to source alternative products from different countries of origin to maintain business continuity. NHS Supply Chain is committed to supporting you and will endeavour to meet your needs. If you require any further information please contact your customer service manager."

7.31 From early in 2020, therefore, SCCL was taking steps, with the approval of DHSC, to counter issues with over-ordering and were taking steps to communicate that in the most effective way through its website. Throughout the pandemic further messages to customers were published through our website with the approval of DHSC. There are a very large number of ICNs (633 for 2020, 543 for 2021 and 929 for 2022) and the vast majority do not relate to PPE or are only tangential to issues covered by the Inquiry. The archived ITNs are not searchable. Their content can only be ascertained by physically opening them and to complicate matters further a new version would be saved any time there was a small amendment. Given that the Inquiry has specifically said that it does not require large quantities of material that is unlikely to touch on key issues I have simply, for now, set out the text of the ICN of 3 February 2020 so that the Inquiry is aware of communication via our website. However, if the Inquiry does require us to search for and disclose all ICNs relating to PPE then we will of course do so.

7.32 Demand control (rationing) was not routinely communicated widely at the start of the pandemic as this often serves to encourage customers to place multiple orders to get around any rationing which defeats the objective of ensuring all orders are fulfilled at least in part, i.e. a fair share goes to all customers The rationing process at that time took the average demand by requisition point and applied it to everyone. Later NHSE created a demand management system.

7.33 Demand is monitored routinely by the NHSSC Inventory Management Team and orders placed to meet demand well in advance but the unprecedented increase in demand for PPE, ICU consumables and ventilators could not have been foreseen. To facilitate the huge volumes going through the network, all orders for stationery were suspended from mid-March 2020 to focus on PPE.

7.34 The level of demand for PPE and other healthcare products reached unprecedented levels by March 2020. As described above, initially, SCCL tried to manage demand by cancelling down orders. It would not be possible to put a number to how many orders were cancelled in this way as there would be no formal records. A lot of it would have come about through direct contacts and discussions between the Customer Service team and individual customers. In addition, our IT system would cancel an order for an individual product line if there was no stock and, due to its age, would not be able to suggest alternatives that were in stock. Accordingly, it is not possible to provide details of which specific products were subject to demand management. It would have affected any product where demand was high but as I have explained demand for all products increased very significantly in early 2020.

7.35 The imposition of a form of rationing was to prevent the whole business being totally overwhelmed dealing with unprecedented demand for everything, not just PPE and had been implemented in discussion with DHSC. On 18 March 2020 Alan Wain of SCCL wrote to Emily Lawson of NHSE confirming that unless he heard otherwise from DHSC and PHE all rationing would be removed from 3pm that afternoon.

7.36 As a result of lifting the demand control, Trusts placed large "surge" orders considerably out of line, in most cases, with their actual need and with no visibility on our side as to the accuracy of that demand. So, while we were liaising regularly with our customers this was not particularly effective because on the one hand there was an unprecedented level of demand for both PPE and BAU items as Trusts reacted to the considerable uncertainty by looking to stockpile (notwithstanding advice to the contrary both from SCCL and wider government) while on the other hand there was no system which tracked and recorded where the stock was. The peak daily demand for delivery in March 2020 reached 220,000 different individual product items (or SKUs "Stock Keeping Units"). By comparison, the demand figures for the same date in March 2021, 2022 and 2023 were 122,199, 144,532 and 126,224 SKUs respectively.

7.37 Demand from all customers increased, including from those who had not traditionally bought through us. What those other procurement teams were starting to find was that traditional lines of supply were closed down or exhausted so they began to turn to SCCL putting greater level of strain on our

supplies. The behaviours exhibited by Trusts were a constant challenge. As an example, if we said a product was subject to demand management then Trusts would try to get around any restrictions imposed by (for example) ordering from multiple different requisition points within the same Trust. What I mean by this is that large Trusts would have more than one ordering point within the same Trust. For example, it might have a central ordering point but could also order from different departments within the same Trust or from different buildings or hospitals within the same Trust. This happened irrespective of any resilience plan which might have existed and the behaviours exhibited were analogous to the activity of the general public, namely stockpiling.

7.38 In other words, despite regular contact with our customers we were never getting accurate information because the instinct of Trusts was to build stockpiles of products in case of need. Our understanding was that this was contrary to clear instructions from DHSC/NHSE that there was no need for stockpiling and messages via our website as referred to at paragraph 7.28 to 7.31 above. SCCL received assurances from DHSC that Trusts would be asked not to stockpile in the expectation that guidance would be followed for the overall good of the system.

7.39 A major difficulty with the system as it was set up was that, while SCCL had an idea of what was being ordered by Trusts, it had no way of tracking what the individual Trusts actually already had as there was no centralised information on inventory. As such, it was quite likely that a Trust could be ordering more of a particular product while it already had significant existing stocks while another Trust might be legitimately ordering because it had run out. There was no way of tracking individual stock-holdings once the order had been delivered nor usage of the relevant products.

7.40 Accordingly, we did not have any way of tracking what Trusts ordering from us already had, in order to prioritise one Trust over another or one product over another. Our lorries have finite capacity and can only make a certain number of deliveries per day.

7.41 Both DHSC and NHSE were well aware of these issues. From early 2020 there were 3 planned daily up-date calls involving multiple agencies from Government, NHSE and the Army. These calls took place first thing in the

morning, in the middle of the day and in the evening. The calls reviewed stock availability, need and demand. In addition to these planned calls there would have been regular informal contact on an hour by hour basis as needed. So there is no question that this issue of how to properly identify need and supply was a very live issue. I am not aware if any minutes were kept of the planned calls and I doubt if there are any records of the many informal daily interactions. DHSC may have some formal minutes.

7.42 It was recognised that a demand led system would not work. As such, around May/June 2020 Palentir were commissioned by DHSC/NHSE to develop a dashboard to attempt to gather the information to show what inventory was where and what the actual need was.

7.43 On 1 May 2020 a letter was sent to all Trusts from DHSC (signed by Jonathan Marron of DHSC and Emily Lawson of NHSE) directing that procurement of PPE should take place on a national basis and not by individual NHS organisations competing with one another for the same (limited) supplies.

7.44 The absence of a centralised inventory management system clearly gave rise to serious issues during the pandemic because, as explained above, it was impossible to know how much stock of a particular product a specific Trust (or the wider system) held. There is a recognition that this problem will be alleviated were every Trust to have an inventory management system which would give greater visibility of stock held in particular hospitals. At the moment, only a relatively small number of NHS Trusts have such a system. SCCL is taking steps to address this in conjunction with NHSE and to instigate an inventory management system in more NHS Trusts but the extent of funding available for this is limited at the moment so progress is relatively slow. We have received committed funding of £14.7 million out of total costs of £19.6 million to pilot a new system with 20 Trusts over a two year period. This will allow those Trusts to use a common approach and NHS Supply Chain will be able to access data on what is actually available and utilised as well as, for example expiry dates of products. We would recommend that all Trusts have an inventory management system but we acknowledge that it comes at a cost for which funding is not immediately available.

7.45 In respect of PPE, the remit of NHS Supply Chain was expanded to facilitate the ordering and delivery (but not procurement) of PPE to the wider NHS and social

care settings. With the assistance of E-bay, DHSC developed an e-portal which enabled smaller health care bodies to order PPE. SCCL would respond to orders placed through the e-portal by picking and packing the items and facilitating delivery through its arrangement with Clipper Logistics (further details of which are set out paragraphs 11.8 and 14.3).

8 Just In Time Contracts

8.1 The principle behind 'just in time' contracts is to avoid tying up capital in inventory by stocking it for months in advance and instead providing for finished product to arrive a few weeks before it is needed.

8.2 I cannot comment on other supply chains serving the NHS or care settings but in relation to NHS Supply Chain's BAU activity we would usually receive product 2 ½ weeks in advance of it being ordered by customers, distributed and used (the exact lead time would vary by product, supplier stock, country of origin and its criticality). In other words, we typically held about 2 ½ weeks of stock.

8.3 The use of just in time contracts by NHS Supply Chain was widespread but dictated by constraints on storage cost and capacity and budgetary factors. It is worth noting that where a decision had been taken by DHSC that a greater depth of stock might be needed in certain circumstances then the stock hold was greater. Examples of this are both the PIPP Stockpile, where just in time contracts were generally not used and the EU Exit Stockpile which was built up in anticipation of potential supply issues in the event of a hard exit from the EU.

8.4 Inevitably 'just in time' contracts were affected by the pandemic which saw a huge surge in demand globally for some items and therefore an inability for stock hold to keep pace with demand and to be replenished.

9 Supply Chain Resilience

9.1 There was significant disruption to supply chains in place for NHS Supply Chain during the pandemic as a result of the world-wide impact of Covid-19. Supply chains were disrupted by lockdowns which halted production.

9.2 In addition to practical problems caused by lockdowns and shipping delays there was also disruption caused by foreign government interventions for example by imposing export bans on high demand items.

9.3 Because of the way NHS Supply Chain was structured at the time of the pandemic it would have been up to the individual CTSPs and the Logistics provider to have and maintain business continuity policies. For example, it was a contractual requirement for Unipart, as our logistics provider, to have a business continuity plan although most of this would have covered accessibility of warehousing and distribution in an emergency. The CTSPs' business continuity plans were audited annually under our contracts with them. Those audits considered whether the plans set out suitable continuity and recovery plans, how often it was tested (and the outcome of such tests) and details of any subsequent actions. As far as I am aware those plans were satisfactory but it would be fair to say that even the best business continuity plans would have struggled to deal with the supply implications created by the pandemic.

9.4 SCCL did have its own plans in place for a range of events including in relation to the disruption of supply but, again, the modelling for these did not envisage the sort of worldwide pandemic that was experienced during 2020. Those plans included circumstances of network disruption. Sourcing from multiple suppliers is routine and enables product substitution where supply chains are disrupted. SCCL uses a supply chain mapping tool to manage upstream supply chain risks and since the pandemic has also introduced a resilience team to improve the management of any supply disruptions and minimise the impact on customers.

9.5 Under the FOM, procurement strategy fell under the scope of services provided by the CTSPs so it would have been their responsibility, in consultation with SCCL, to consider questions of supplier resilience as part of the creation of a category and sourcing strategy for each type of product that they procured. This would have included how to deal with short term disruptions. This would include the level of stock-hold over a particular period to cover any short term disruption. Generally, SCCL requires suppliers to hold 4 weeks stock of BAU products in the UK. However, supply chain disruption was something which SCCL was starting to consider in more detail including finding a partner to assist with supply chain mapping. However, this work was disrupted by the advent of the pandemic.

9.6 There were some specific cases where H M Government had identified the possibility of widescale supply chain disruption and would have a separate strategy to deal with that. Examples of this would be the creation and

management of the PIPP and EU Exit stockpiles which I describe later in my statement.

9.7 In both cases, H M Government had identified a particular risk to supply chains and had made a decision about how to mitigate the effects of that. SCCL would help to implement those policy decisions but would not make any plans itself to deal with supply chain disruption.

9.8 In any event, the problem was not generally where suppliers were based but where the products themselves were manufactured. For a variety of economic reasons, more and more production, particularly of items of PPE, had become concentrated in the Far East and Asia. SCCL were never reliant on a single supplier but suppliers themselves might be dependent on only one or two manufacturers based in particular parts of the world.

9.9 For this to change and for supply chain disruption to be minimised then the push factors for production overseas would have to be reversed and more incentives given to UK manufacturing to bring manufacture back in-country.

9.10 SCCL, through the CTSPs, had access to a wide range of suppliers with whom it already had a contractual relationship and which had already gone through the appropriate checks and due diligence required to win a place on a framework. They were a 'known' quantity. Through its frameworks, SCCL had access to most, if not all, of the established suppliers in a particular market so access to suppliers was not particularly an issue during the pandemic. The real issue was the ability of suppliers to obtain goods from their manufacturers.

9.11 There was very little SCCL could do to overcome this problem which was a global issue and not specific to the UK. However, because it did have a range of existing suppliers it was able to leverage those relationships so, for instance, it might ask an existing supplier of (say) facemasks if it was able to supply another product and that could then be followed up. In the case of items of PPE this contact would be followed up by the PPE Cell.

9.12 Generally, the contracts supplying NHS Supply Chain did have provision for a surge in volume. When a framework agreement is advertised under the PCR it will have a ceiling on value and requirements for making volume available when there is a call off. Accordingly, in normal circumstances, the framework agreement would give sufficient headroom to enable SCCL to place orders as

and when needed as the ceiling would be set at a level that would ensure that we had access throughout the life of the framework. However, the pandemic represented a period of unprecedented worldwide demand. For the highest demand products such as PPE, the demand was such that the thresholds (which were based on historic demand) were insufficient to meet the requirements of the pandemic. In that case, SCCL made use of direct awards under PPN 01/2020. For the majority of other clinical consumables (for example procedure packs where demand reduced significantly) the framework threshold was sufficient. In respect of some non clinical consumables (such as pulse oximetry) framework thresholds were exceeded.

9.13 The constraint on supply, as I have explained, was not with suppliers but the ability of manufacturers to provide product in the face of global demand and the constraints imposed by lockdowns due to the pandemic.

10 NHS Supply Chain during the Pandemic

10.1 NHS Supply Chain continued to operate throughout the pandemic in relation to its BAU activities. Apart from PPE, SCCL's BAU procurement continued as it did prior to the pandemic. SCCL's BAU procurement was not widened to other NHS bodies or care settings.

10.2 In relation to its procurement functions during the pandemic, NHS Supply Chain continued to use established framework agreements and contracts that were already in place with known suppliers. NHS Supply Chain only dealt with such suppliers during the pandemic. We also continued the cycle of regularly replacing expiring frameworks with new frameworks through procurement.

10.3 As part of the process of appointment to a framework agreement a supplier will go through a series of financial and other checks as part of the standard 'selection' process. As I have explained at paragraphs 4.1, 4.3 and 4.4 above, this process follows a template prepared by the Crown Commercial Service and includes certain mandatory questions about financial probity.

10.4 Because NHS Supply Chain was only dealing with existing suppliers during the pandemic those suppliers were effectively 'pre-qualified' and no further counter-fraud checks were undertaken.

10.5 Responsibility for counter-fraud checks on procurement of PPE by DHSC during the pandemic would have been the responsibility of DHSC/the PPE Cell and not SCCL.

10.6 SCCL made payments to existing suppliers only ie those which were already on existing framework agreements. The payments made were pursuant to the contractual arrangements in those framework agreements.

10.7 HMRC did not require SCCL to go through any processes when making payments or identifying potentially suspicious contractors.

11 SCCL and procurement of PPE by DHSC during the pandemic

11.1 Prior to the pandemic there was no specific category of goods designated as PPE due to the relatively small amounts of these products which have now come to be included within that term required each year. The procurement of items within the definition of PPE was managed through several of the CTSPs most notably, Tower 2 but also by Tower 8 (hand hygiene) and Tower 11 (polymer aprons, body bags and clinical waste bags). Procurement of these items by the CTSPs was part of SCCL's BAU operation which I have described earlier in this statement. Spend on what is now classified as PPE formed a very small proportion of our total spend in the years before the pandemic (see enclosure PBW07 [INQ000438168]).

11.2 By March 2020 high demand across the whole range of SCCL's catalogue threatened to completely overwhelm its operation and a decision was therefore taken by DHSC/Cabinet Office to establish a separate "PPE Cell" which would be tasked specifically with the procurement of PPE at the direction of DHSC. Associated with that, we were instructed by DHSC to set up a separate distribution function for PPE using Clipper as a sub-contractor of Unipart, SCCL's main logistics provider.

11.3 As part of the establishment of the PPE Cell some personnel from the CTSPs were 'loaned' to the PPE Cell. For example, a team from the Tower 2 CTSP, CPP LLP, was loaned to the PPE Cell but remained employed by CPP LLP. Within the PPE Cell there were separate teams: China Buy, UK Make and the personnel 'loaned' by the CTSPs who were tasked with securing PPE from existing suppliers leveraging existing relationships.

11.4 All the purchasing by these teams was at the direction of DHSC but SCCL facilitated the purchase of items by using its existing framework agreements to enable orders to be placed with existing suppliers.

11.5 The procurement of PPE was at the direction of DHSC. However, as I have described above SCCL assisted with procurement by allowing CTSPs to 'loan' staff to the PPE Cell and by leveraging relationships with existing suppliers from current framework agreements. In addition to DHSC NHS England would also have been involved in decisions on procuring PPE including in relation to what items should be procured.

11.6 SCCL had no role in relation to the procurement activity of the Parallel Supply Chain and High Priority Lane.

11.7 SCCL provided no guidance to the PPE Cell on the selection of contractors in the Parallel Supply Chain or High Priority Lane nor what due diligence should be carried out. It did provide benchmark pricing based on framework agreements procured pre-pandemic but did not advise on what prices constituted reasonable value for the taxpayer in the context of the pandemic. It also gave no guidance on counter fraud measures. These were matters which are all covered by the PCR and the guidance associated with it.

11.8 In relation to distribution of PPE, there was a large team, including NHS England and the Ministry of Defence involved in the decision making in relation to establishing the separate logistics and distribution support specifically for PPE leading to the appointment of Clipper. However, all engagement by SCCL with the Ministry of Defence and others was at the direction of DHSC.

11.9 These interactions would have been on a frequent basis over the course of the day so it is not possible to give each individual example of how this worked in practice but SCCL were a part of the team which worked on a daily basis to try to determine need and to prioritise the distribution of PPE. Representatives from both NHS England and MoD were in those teams but so too were DHSC and other agencies across government.

11.10 Under BAU, and prior to the pandemic SCCL had a Clinical and Product Assurance ("CaPA") team which was responsible for ensuring that products supplied by NHS Supply Chain met the required regulatory standard. Although it was the responsibility of the CTSPs to procure items which had regulatory

approval the CaPA team would check this and would refer any doubts to the regulatory authorities. The regulatory standards and technical specifications were not set by SCCL. They were set by the relevant regulatory body such as the British Standards Institute. The CaPA team would check to ensure that items had a CE mark or equivalent. If there was any doubt whether the mark was equivalent then it would be referred to the regulator.

11.11 As demand for PPE increased and new suppliers and manufacturers were coming forward there was concern on the part of the CaPA team that they were being asked to 'approve' items. This was not the role of CaPA. Any question about whether a product met the standard had to be referred onward to the relevant regulatory authorities and that inevitably led to delays.

11.12 I understand that this was the background to the 1 April 2020 letter from the Secretary of State for Health and Social Care to SCCL's CEO authorising it to "*disapply normal expectations on PPE standards and to act on the basis of directions from the Cabinet Office*". A copy of that letter is at PBW05 [INQ000425391].

11.13 I cannot say what effect this had on buying decisions as PPE buying decisions were no longer in the hands of SCCL by that time. However, prior to receiving this letter SCCL would reject anything which was not CE (or recognised equivalent) marked. After receipt of the letter SCCL would not automatically reject product that was not CE marked or had full regulatory approval but was entitled to rely instead on the buying direction it had received. As the letter set out, if the purchase was directed by the Cabinet Office then SCCL could rely on that direction as authorisation in relation to the application of regulatory standards and was not required to make further enquiry. This was with the intention of speeding up supply from new manufacturers. I am unable to comment on the process which would lead to a purchasing direction from Cabinet Office and this is something which would need to be followed up with Cabinet Office and DHSC. SCCL did not query this direction with any regulatory authority.

11.14 From early April 2020 the CaPA team was working with Deloittes and the Army to develop a 'playbook' to enable the PPE Cell to ask the right questions about technical specifications. Over time, these questions were built into a more streamlined web based system which was developed on the instruction of

DHSC. However, this did not include sizing requirements as this was not an issue prior to the pandemic. Although the CaPA team assisted in developing a playbook and work flows to enable the right questions to be asked the decision on whether something did or did not meet regulatory requirements was not made by them. Where a buying direction was in place following the letter of 1 April 2020 then that is what would have been followed. The CaPA team would not have had input into those directions and would not have needed to raise questions about the guidance because, following the publication of the letter, responsibility for purchasing PPE moved to the DHSC PPE Cell which would have been responsible for ensuring the standards were met. The quality assurance team in the PPE Cell would have dealt with any complaints from customers, they would not have come to SCCL.

12 New Suppliers (not used prior to 31 December 2019 for the supply of PPE- Contracts (formation, monitoring and enforcement)

12.1 As I have explained elsewhere in this statement SCCL only dealt with existing suppliers during the pandemic. I am therefore unable to answer the questions in the Rule 9 request relating to the position of new suppliers ie those not used as at 31 December 2019. These questions should be directed to DHSC.

12.2 I am aware from a DHSC publication dated 17 November 2021 (PPE procurement in the early pandemic - GOV.UK (www.gov.uk) that some referrals of new suppliers may have been made by individuals employed by the CTSPs but 'loaned' to the PPE Cell. My understanding is that all such referrals were made to the PPE Cell and actioned by them.

12.3 Because it was only dealing with existing suppliers who were already known to it, SCCL did not treat any approaches or bids or contracts as suspicious or fraudulent.

12.4 I am aware of one supplier, **CSI** which was investigated by DHSC in relation to the supply of FFP3 facemasks which were found not to meet the technical requirements for FFP3. Although I am aware of this case, SCCL did not investigate it. That investigation was carried out by DHSC and I do not know what the ultimate outcome of that investigation was. I believe that the Department is therefore best placed to answer any questions the Inquiry has about this.

12.5 SCCL does not know about prosecutions arising from any bids or contracts which HMG treated as suspicious or fraudulent. SCCL does not know any details of new suppliers for PPE who were treated as fraudulent or suspicious or what, if any, action was taken in relation to them.

13 Contractual Monitoring, Compliance and Enforcement

13.1 All contracts entered into by SCCL following procurement were on the standard terms and conditions for NHS contracts. A template is attached at PBW06 [INQ000425392]. The standard terms and conditions were cross-referenced in the call off purchase order from the framework agreement. I also attach a template call off as part of PBW06a [INQ000425393].

13.2 Under its contracts with the CTSPs SCCL was able to monitor their performance in line with normal contract management processes and procedures. There were no instances of significant under-performance which would have led the relevant contract to fall into default.

13.3 CTSPs were managed via a suite of key performance indicators which, if not achieved each month, would impact their gain share percentage (i.e. the "profit" element of the payment mechanism. Each CTSP had a Category Tower Manager from SCCL closely managing the CTSP performance and working with them on a day-to-day basis and a monthly performance and management reviews took place with each CTSP. Each CTSP had to operate within their agreed operating cost envelope which was closely monitored by SCCL on an open-book basis and subject to regular audit.

13.4 The standard terms and conditions include terms to deal with:

13.4.1 Default provisions;

13.4.2 Consequences of underperformance including financial consequences;

13.4.3 The responsibility for checking technical specifications;

13.4.4 The consequences of late delivery;

13.4.5 Consequences for misrepresentation;

13.4.6 Mechanisms for increase/decrease in volumes of goods ordered;

13.4.7 Termination for cause; and

13.4.8 Provisions for contract variation or change.

13.5 During the pandemic, SCCL only dealt with suppliers of PPE who were known suppliers on existing framework agreements. It had no involvement with new suppliers of PPE who were identified by the PPE Cell. SCCL had no involvement with contracting with those suppliers or, therefore, the monitoring of compliance and enforcement of breaches. Those matters would be the responsibility of the PPE Cell under direction from DHSC.

13.6 As regards existing suppliers they would be monitored under the terms of the framework agreement contracts which I have described above at paragraph 13.1 above.

13.7 SCCL is only aware of one instance of a major issue with contract performance in relation to an existing supplier. In that case, a contract with a French supplier, CSI for FFP3 facemasks was not performed because the French Government imposed an export ban.

13.8 On behalf of PHE SCCL has recouped £450,000 and 25,600,000 additional type IIR facemasks from CSI from its failure to deliver under a contract for the supply of FFP3 facemasks.

13.9 The original contract was a framework agreement dated 20 January 2017 and was between CSI and DHL Supply Chain Limited in its capacity as agent for the BSA. On 1 April 2019 this contract was novated to SCCL. On 5 February 2020 a call off contract was issued to CSI for the supply of CSI FFP3 face masks.

13.10 The value of the contract was CSI excluding VAT albeit no payment was made to CSI

13.11 The contractor failed to deliver because the French Government imposed an export ban which prevented the supply of the facemasks as provided in the contract.

13.12 On 20 November 2020 SCCL threatened legal action by way of a letter before action addressed to CSI

13.13 Pre-action letters were sent and the matter was resolved at CSI with a settlement reached as follows:

13.13.1 CSI would pay a total of CSI by way of damages; and

13.13.2 CSI would provide CSI Type IIR facemasks over a period of time.

14 Storage and Distribution of PPE procured by DHSC

14.1 I need to draw a distinction between 'hospital consumables' which fell within SCCL's BAU activity during the pandemic (and was not purchased by DHSC) and PPE which, as I have explained elsewhere, was hived off into a separate 'PPE Cell' and was purchased by DHSC.

14.2 In respect of the BAU activity SCCL retained its responsibility for storage, inventory management, stock rotation, monitoring of expiry dates and distribution and this was managed through its contracts with Unipart (and Movianto in respect of the PIPP stockpile).

14.3 In relation to PPE, which was purchased by DHSC through the PPE Cell, Clipper was appointed to deal with the logistics and distribution of PPE. SCCL was not involved with the decision to appoint Clipper but oversaw the setting-up of the logistics operation once Clipper were involved. Contract management of Clipper was through the creation of a sub-contract with the BAU logistics provider, Unipart, and this included the taking of additional warehousing as needed for storage of PPE. Unipart were responsible for managing Clipper with support and direction from SCCL.

14.4 SCCL's role in relation to the logistics operation for PPE was effectively to act as a consultant and a contractual vehicle but all decisions were taken by the PPE Cell at the instruction of DHSC.

14.5 Although not involved in the decision making, SCCL were instrumental in designing the concept, implementation and delivery of the logistics services for PPE (as well as medical technology required for ICUs and Covid vaccine supply). In May 2020, SCCL designed the stock allocation and distribution control process that was eventually incorporated into the 'Foundry System' which was created by Palentir at the request of NHSE. This gave senior

decision makers real time visibility of available stock supply against the context, volumes and destination of demand requirements.

14.6 In addition, SCCL staff were working flat out to assist the Army and Clipper with product identification, process and Standard Operating Procedure implementation in the core warehouses in order to support stock availability for PPE. The same people were also involved in supporting broader Covid responses such as the Nightingale hospitals. This involved standing up a further additional supply chain, a dedicated technology warehouse and distribution solution through DHL and their warehouse at Skelmersdale.

14.7 In terms of challenges, setting up a logistics operation from scratch is very complex and usually requires months of preparatory work. Although Clipper were an established logistics provider they had no experience of working in the health care sector. In order to set up a logistics operation to support the storage and distribution of PPE across the NHS and social care all parties were starting from scratch.

14.8 The most basic information for establishing an effective supply chain was not there. SCCL knew what was wanted but basic information such as where it should go (for example addresses or location details), how much was needed, what the forecast of demand was and therefore who might be supported most effectively simply did not exist. SCCL had insufficient useful data to help to establish the parallel supply chain as would normally be the case, but nevertheless had to help to get the operation up and running effectively as soon as it could.

14.9 In other words, the challenges were very substantial in establishing a parallel supply chain more or less from scratch. It was only achieved by the hard work of everyone involved, including SCCL management and staff who were working 24/7 in the first months of the pandemic, Clipper, the Army, DHSC and others.

14.10 As the pandemic progressed and more data became available to support the logistics operation problems caused by lack of information began to ease but in the very early days there were huge challenges in setting up a parallel supply chain and it was only achieved by all involved working together to achieve it.

14.11 I have described what responsibilities SCCL had in relation to monitoring the expiry dates of stock in the PIPP stockpile at paragraphs 17.26 to 17.35 below.

14.12 In relation to stock management for its BAU activities SCCL had an inventory management team which was monitoring levels of stock and date expiry constantly. During normal operation, the volume of stock held works on a simple "Supply equals Demand" basis over a set period of time. Should demand increase or decrease, the volume of supply is adjusted to compensate and this contains the risk of stock reaching its expiry date. This process operated for normal NHS Supply Chain product flows during the pandemic.

14.13 The process of stock monitoring during the pandemic developed over time and was continually improved and optimised. Initially, the reporting structure captured information on the total available PPE stock position and reported this 3 times a day (07.00 am, lunchtime and 18:00) to stakeholders within NHSE and DHSC. The report at 18:00 presented a stock picture that provided stakeholders with the ability to allocate stock volumes in a 'stock push' model to meet demand requirements. This allocation was then provided to NHS Supply Chain to process and prepare the relevant supply for shipment to the appropriate destination.

14.14 The 07:00 stock position report detailed what had been processed overnight, deliveries that were in progress and expected delivery completion. As procurement of PPE by the PPE Cell ramped up this daily process was enhanced to include the 'pipeline' view of stock shipment from suppliers and evolved into the Foundry system created by Palantir and described above. As the PPE Cell and supply chain through Clipper evolved NHS Supply Chain ceased to have an operational role from May 2020 onwards.

"Excess Stock"

14.15 It is important that the Inquiry does not conflate unplanned, or excess, stock provision with planned stock provision such as the PIPP stockpile which was managed under a separate contract on behalf of PHE or with the EU Exit stockpile which was effectively a planned holding of additional stock in order to mitigate the effects of a hard exit from the EU. That planned stock hold could simply be released into NHS Supply Chain's BAU activity once it was clear that there was in fact no disruption.

14.16 Accordingly, when it comes to potentially comparing costs you are not comparing the same thing when looking at excess PPE and the PIPP stockpile.

The storage for the former was, to a degree, ad-hoc whereas the storage for the latter was planned and the type of storage is different. Excess PPE might have to be stored in containers on the dock at a port whereas the PIPP stockpile comprised 'deep storage'. Also, the PIPP stockpile was split between a pharmaceutical response, requiring specialist storage in a different part of the country, and a 'consumables response' which was stored elsewhere.

14.17 In other words, I do not consider that there is any meaningful way of comparing the planned costs for a particular type of storage for the PIPP stockpile with the cost of storage of excess PPE.

14.18 SCCL did make provision for the storage of excess PPE bought by DHSC by facilitating additional warehouse space for use by Clipper. This was principally managed contractually through the contract with Unipart and the sub-contract to Clipper but also included contractual arrangements either directly with storage companies or the suppliers of the products in question. This enabled more capacity to be added to NHS Supply Chain's existing storage. Decisions on warehousing were taken by DHSC and ultimately it was paid for by DHSC but at PBW 09 [INQ000438170] I have attached a further chart showing the costs of storage which we have invoiced to the DHSC as being outside our BAU activity. This includes storage for a variety of items, principally PPE but also including other core products used as part of the response to the pandemic (for example, ventilators and oxygen).

14.19 I do not know what the total spend to date of disposing of excess PPE is. PPE was purchased by DHSC during the pandemic so any question about costs should be directed to DHSC. SCCL recharged its costs to the Department and it is the Department which has been supporting the costs of providing free PPE across the NHS and social care settings up to March 2024. From a government announcement on 22 December 2023 I note that the value of the free PPE scheme for the period 1 April 2021 to 31 March 2023 is around £471,385,725. Based on the free PPE scheme it would be difficult to identify what PPE is regarded as 'excess' for the purposes of this question.

14.20 However, at PBW 10[INQ000438167] I attach a chart which shows the total cost to SCCL of disposing of PPE since we took responsibility for disposal in April 2023. Disposal here refers to the costs associated with any of donation or sale of products and disposal via energy from waste or recycling (depending

on the type of PPE) with the majority coming from disposal as opposed to sale or donation. These are the disposal costs recharged to the Department which I refer to at paragraph 14.19 above.

15 Intensive Care (ICU) Supply Chain

15.1 In response to Covid-19, the DHSC decided to establish a stockpile of products used in the delivery of ICU care.

15.2 The initial planning for the number of ICU beds needed was 35,000 based on modelling from Deloitte, with the input of physicians.

15.3 At the request of DHSC, SCCL set up a dedicated ICU supply chain with DHL on 27 March 2020 and which was operational by 30 March 2020. This shipping channel was operated out of a fulfilment centre at Skelmersdale in respect of which DHL were managed by SCCL. The purpose of the separate channel was to deal with surge demand for the Nightingale hospitals without impacting the BAU supply chain.

15.4 In the event, the Nightingale Hospital at London ExCel took very few patients and was stood down. Some other regional centres were opened but were never used. However, the supply chain provision had been made including the acquisition of consumables (which had to be stored) and the development of contractual arrangements with third parties (which no longer matched what was required).

15.5 The DHSC is better placed to provide details of the rationale behind the selection of products and what SCCL were instructed to procure.

15.6 SCCL was, at the request of DHSC, responsible for purchasing as many of the products required for the ICU supply chain as it could through its normal BAU frameworks.

15.7 For the most part, orders placed for items in the ICU supply chain were placed with suppliers who were already on existing framework agreements. Accordingly, they had already been through a process of competitive tendering and open competition.

15.8 It is likely that some orders from framework agreements were made by Framework Direct Award but such an award would only have been from a framework which had already been subject to open competition.

15.9 I understand from speaking to colleagues internally that with some items (for example Ventilators, Video Laryngoscopes and O2 concentrators) the 'Difficult-to-Source' Team within DHSC would have been responsible for procurement in the main because the products were not available through our normal routes. That procurement would have been undertaken by DHSC and I cannot comment on the routes for procurement used by that team.

15.10 Where purchases were made by SCCL, contracts were placed with existing suppliers so they would have been suppliers already on framework agreements. Those suppliers would have been appointed under an open competition for the framework agreement which would have been initiated by publication of a notice to the market-place in accordance with the PCR. Any supplier who wished to be on the framework would therefore have responded to that notice and the call for competition.

15.11 As the buyers for the ICU supply chain were utilising existing frameworks there would have been no documents covering establishing the market, undertaking due diligence or reviewing conflicts of interest and the carrying out of technical assurance would have been undertaken as part of the work in connection with the competition for the framework agreement. Once a supplier was on the framework agreement then these matters had already been checked and had been assured. The relevant buying team would have simply responded to the DHSC's list of products and relevant quantities to instigate procurements from the frameworks.

15.12 Equipping an ICU bed requires all the consumables that go with the bed. The original plan called for 921 products which equates to about 18,500 pallets based on the 35,000 beds referred to above. Subsequently, SCCL were advised that there would be 2,900 products equating to about 80,000 pallets.

15.13 These products ranged from syringes and tubing to bed linen, to ventilators. A full list of all products (running to some 270 items) can be provided to the Inquiry if needed.

15.14 SCCL does not have the information to advise on what proportion of goods procured for the ICU supply chain were in fact used during the pandemic. Similarly, we do not have the information to advise about any 'excess stock' although I would note that stock is only 'excess' if it cannot be used at all anywhere within the supply chain.

16 Care Settings during the Pandemic

16.1 Prior to the establishment of the PPE Cell, SCCL did its best to support the emergency response to community care settings and local authorities. SCCL's BAU logistics' operation is based on a model of large lorries to large customers whose facilities are open 24/7. That made it very challenging to respond on a small scale to small local providers which kept regular opening hours. SCCL had no record of the locations of all those care settings which required PPE and no such complete record existed and had to be drawn up from scratch.

16.2 Very early on in the pandemic the Secretary of State for Health and Social Care made a public statement that all care settings would receive a delivery of PPE by the end of that week and SCCL was tasked with facilitating this.

16.3 This initial distribution was very much ad-hoc. So much so that SCCL had no advance notice of the Secretary of State's promise. There was no list or plan of where all these care settings were. SCCL's logistics provider, Unipart, had access to a parcel network through DPD so this network was used to distribute this PPE. Again, while Unipart had access to such a network it had never been utilised to the scale needed during the pandemic so actually getting small quantities to where they needed to be was a challenge

16.4 There were difficulties because the van might go to the location only to find it shut as it was out of hours and unable to receive deliveries and there might then be difficulties in re-arranging the delivery. So although the capacity existed to make the deliveries there were delays in effecting the delivery.

16.5 As this exercise was very ad-hoc and put together as an emergency response calling in favours from our logistics provider no performance or other records were kept. There was no set of KPIs against which the emergency response could be measured for an activity which was not part of BAU so there was nowhere where such data could be kept. SCCL was asked to undertake this

exercise at extremely short notice and it did what it could to stand up a service capable of delivering the 'ask'.

16.6 In order to overcome this, initially SCCL called in favours and was able to stand up the service on an ad-hoc basis. SCCL had never dealt with these customers before and it is extremely difficult to pick, pack and distribute product to customers knowing nothing of who they are or where they are located. Accordingly, there were instances of delay as part of this emergency response but for the most part this was as a result of the recipients not being available to take delivery of the goods and not caused by any systemic problem.

16.7 However, in the longer term, an 'e-Bay-style' e-portal was established which enabled providers to order what was needed and to arrange delivery at times which were convenient to them. The picking and packing of that service was handed over to a dedicated PPE logistics operation provided by Clipper which was separate from SCCL's BAU logistics but under the overall management of SCCL.

16.8 In order to facilitate this arrangement it was set up as a sub-contract of SCCL's contract with Unipart. Distribution of PPE was centralised from Clipper's warehouse at Daventry with additional warehousing added as the pandemic progressed and more space was required. Again, the additional warehousing space was sub-contracted through SCCL's contract with Unipart. These contract extensions were made at the direction of DHSC.

16.9 I have advised the Inquiry that these contractual documents can be made available if requested. I have not enclosed them now as they run to hundreds of pages of text much of which may be considered irrelevant.

16.10 SCCL supported the government in relation to this further distribution by providing a contractual framework and managing the overall logistics operation both for BAU operations as well as PPE and ICUs. However, instructions as to how these should be operated came from the PPE Cell and DHSC.

17 PIPP Stockpile

17.1 The PIPP stockpile existed prior to the incorporation of SCCL in 2018. It was established following the 2009 swine flu outbreak and was a joint project between DHSC and what was then PHE and is now UKHSA. For the sake of clarity, I will continue to refer to PHE in this statement. Originally, the stockpile had been controlled and managed by DHL as part of a supply chain contract with DHSC and managed on its behalf by the BSA. The BSA was used as the vehicle for procurement of the products and the management of the logistics arrangements.

17.2 DHL were replaced by Movianto following an open procurement process in 2018 and responsibility for the management of the contract transferred from the BSA to SCCL by novation on 29 November 2018 when SCCL took over the management function of NHS Supply Chain under the FOM (as described above). For the avoidance of doubt, the service provided by Movianto under this contract was wholly separate from the service provided to Unipart referred to in paragraph 5.15 above.

17.3 SCCL entered into a contract with the Secretary of State for Health & Social Care on 21 September 2018 PBW13 [INQ000492084] for the provision of contract management services in respect of contracts for the supply of goods and services to and on behalf of PHE. One of those contracts was the agreement with Movianto referred to above.

17.4 Overall responsibility for the management of the PIPP stockpile (including the process for distribution of the products) sat with PHE.

17.5 The allocation of products within the stockpile and the subsequent allocation of those products across the four nations of the UK was managed by PHE and we are unable to comment on how this would have operated in practice but details could be provided by PHE and/or the devolved administrations. Whilst Movianto held stock for each of the devolved nations, neither Movianto nor SCCL had visibility of the total stock pile across all items for the whole of the UK.

17.6 SCCL had no involvement in the selection of goods that formed the PIPP stockpile. All decisions relating to the composition of the stockpile were taken by PHE. What follows is a description of SCCL's involvement but substantive

questions about the purpose and use of the PIPP stockpile should be addressed to DHSC/PHE.

17.7 A list of products was created as a result of modelling used to inform the PIPP stockpile in 2009/2010 and such products were owned by the DHSC. The product requirements were based on anticipated increases in use of these medical consumable products during the realistic worst case scenario over a 26 week influenza pandemic.

17.8 Subsequent changes to the product type or target volumes within the PIPP stockpile were made on the recommendation of the New and Emerging Respiratory Virus Threat Advisory Group (NERVTAG) which is an expert committee of DHSC and the Clinical Countermeasures Board (chaired by PHE). Most products identified for the PIPP stockpile were at target volume prior to the pandemic. The only item which was not at target volume was gowns which had only been approved for procurement by NERVTAG in November 2019.

17.9 As regards storage, SCCL was responsible for overseeing the contract with Movianto (paragraph 17.3) for storage and distribution of the PIPP stockpile.

17.10 There were two parts to the PIPP stockpile: the storage of anti-virals which would be distributed in the event of a flu pandemic and storage of medical consumables which PHE had determined would be required in the event of a flu pandemic. I will not deal in this statement with the anti-virals as it is not within the scope of Module 5.

17.11 The PIPP stockpile was stored in multiple sites not just the Movianto warehouse as the stockpile included a number of product categories such as antivirals, antibiotics, hygiene products, PPE and airways management. Accordingly, we can only talk about the distribution from the Movianto warehouse. That warehouse, in Haydock, is a shared user facility between various other Movianto customers as well as the PHE held product. It was accessible 24 hours a day and seven days a week.

17.12 The purpose of the PIPP stockpile was to ensure that there was a deployable depth of stock which could deal with the demands specifically of a flu pandemic. The stockpile was there to support the supply chain in the event of disruption caused by a flu pandemic and to cover the first waves of supply to the NHS in

the event of such a pandemic and distributed in accordance with instructions from PHE.

17.13 Under the contract with Movianto, there was a significant hold of approximately 54,000 pallets of products which would be retained in storage perhaps for significant periods of time. Movianto used a warehouse in Haydock for the storage of consumables.

17.14 As regards distribution, the stockpile could only be deployed on the instruction of PHE. The modelling for the composition, storage and distribution of the stockpile was all based on the modelling for a flu pandemic so the need for distribution and the authority to do so all depended on the triggers which would arise once a flu pandemic had been declared.

17.15 There were no delays in the activation of the stockpile or the execution of supply to meet the demand signal. Once a request was made to deliver a volume of product to a location this happened within the requested timeframe of the specific order. The principal cause of delay in deploying the stockpile was a lack of clarity in the demand signal ie knowing what was required and where it was required.

17.16 Any action taken in relation to the stockpile required an instruction from PHE. That said, from late January 2020 it was starting to become clear that supply chains were being affected by the situation in China and other parts of the world and permission was sought from PHE to start moving items out of the stockpile. During February 2020 SCCL was also talking to Movianto about their ability to mobilise the stockpile if needed.

17.17 As demand increased significantly on NHS Supply Chain for all goods but particularly PPE in late February/early March, SCCL arranged with PHE that pallets of PPE could be pushed out from the PIPP stockpile and approval would be sought retrospectively rather than in advance.

17.18 The goods in the stockpile were owned by PHE/DHSC.

17.19 SCCL is not in a position to explain the responsibilities of PHE as the owner of the stockpile. SCCL could only take action in relation to the stockpile on the instruction of PHE so to that extent, the interplay of responsibilities meant that

SCCL responded to the direction of PHE based on analysis undertaken by PHE.

17.20 The PIPP stockpile existed to support the first 26 weeks of a Reasonable Worse Case (RWC) Influenza pandemic. My understanding is that the planning assumptions were that once the PIPP stockpile had been fully deployed (i) the Influenza pandemic cases would be over the worst stages and reducing considerably and (ii) the supplier base would have responded with additional and on-going requirements for products if high demand continued.

17.21 All the modelling on which the preparation of the stockpile was based was only for an influenza pandemic.

17.22 The PIPP stockpile did have enough stock to meet the modelled demand associated with RWC Influenza pandemic.

17.23 It is important to note that because the PIPP stockpile was modelled on an RWC Influenza pandemic it contained a number of products which were not required as part of the Covid-19 response. Accordingly, it was only those items which were needed for the response, specifically PPE, which were deployed from the stockpile. Items which might be needed for an influenza pandemic but which were not required in the response to Covid-19 were not used and did not therefore need to be replenished.

17.24 In respect of items which were deployed these were not replenished during the pandemic as they were required for immediate deployment. SCCL is working with DHSC and NHSE on the provision of future pandemic preparedness and as part of that there are remaining stockpiles of PPE managed by SCCL on behalf of DHSC and NHSE. The contract at PBW13 [INQ000492084] is still in force.

17.25 It was never intended that the PIPP stockpile would be the sole source of supply for PPE and other hospital consumables during the pandemic. It existed to support supply chains in order to mitigate disruption in the event of a flu pandemic. Responsibility for sourcing PPE and other hospital consumables during the Covid-19 pandemic is described elsewhere in my statement to the extent that I am able to provide this information.

17.26 Under the terms of the contract with Movianto, all of the information on incoming products was recorded and retained, including expiry dates where applicable. Movianto's responsibility was to capture the data, maintain its integrity and provide it in a report to SCCL. That report was reviewed monthly by an SCCL team. The purpose of the review was to give a forward view of the inventory, look at expiry dates and, as necessary, arrange for re-testing of the product or the procurement of new product with the older product either being cycled into the normal supply chain or disposed of. The review focused on a procurement cycle of about 12 months and would lead us to make recommendations to PHE on these matters.

17.27 This was because 12 months was roughly the time taken to run a procurement process to replenish stock so recommendations to PHE would be in advance to give us time to complete that procurement process for a new product (or re-testing/shelf-life extension) to be received before existing stock expiry dates.

17.28 In the following paragraphs, I have set out how consumables in the stockpile are dealt with whether by extending the shelf-life, stock rotation, 'swapping out' or product exchange and product cycling. PHE (as the title holder of the relevant products) controlled the monitoring, ownership and authorisation of shelf life extension requests. We have no visibility of the totality of the PIPP stockpile and would not be able to set out the proportion of the stockpile which had been shelf extended at the time of deployment.

17.29 Most products have a 60-month shelf-life from the point of manufacture. Following discussion with the relevant manufacturers, some products (mainly FFP3 respirators) could have their shelf-life extended for up to 10 years after a suitable testing process that involved accelerated aging. Shelf life would only be extended after rigorous and approved testing usually undertaken by the original manufacturer. It involved sending off batch samples that are then 'accelerated aged' by aging them in a type of kiln for 156 days. The item will then be re-tested (either by the manufacturer or an independent tester) to validate its suitability for on-going use and performance. When a product is in the stockpile and deemed appropriate for shelf-life extension then this would be considered at 42 months. This would give time to prepare and send the samples for testing, having it aged tested and independently evaluated with the aim to complete this before the original expiration date. PHE in consultation

with the manufacturer and the logistics provider would make that decision. Shelf-life extensions had been carried out routinely since 2013/2014.

17.30 Once re-evaluated and approved the product would be re-labelled. Often a new label will be placed over the old label with a new expiry date. This is done to avoid damaging the product as might happen were the original label to be torn off and replaced. In any case, the labels actually come from the manufacturer of the products who, by doing so, are endorsing the new expiry date.

17.31 Before the start of the pandemic, the only product that had been stock rotated through NHS Supply Chain BAU activities was examination gloves. Stock rotation means shifting the stock from the stockpile and into the SCCL business as usual supply chain as it begins to approach its expiry date. This is to ensure that the product can be used within its shelf life rather than sit in the stockpile unused possibly well beyond its expiry date after which it can no longer be used. This stock rotation will usually take place in the last 15 months of the product's 36 or 60 month shelf life. This meant that PHE only had to fund the purchase for PIPP once with replenishment funded through the sale of stock as it was cycled from the stockpile to business as usual. It also avoided the cost of waste, disposal and handling costs.

17.32 In addition to stock rotation there were some product exchanges and product swap outs. Product exchanges occurred where there had been, for example, production problems (aprons) or a change in specification (clinical waste containers) in the BAU supply chain. In those circumstances, PHE would agree to supply PIPP stockpile products into BAU which would then be replaced when the disruption had ceased.

17.33 Product swap out means that when a product goes out to tender bidders are offered the opportunity to include a 'swap out'. If a 'swap out' bid is accepted then this is set out in the contract. For example, a supplier may bid 45p for a cannula with a 60-month shelf-life or 54p for a canula with a 'swap out' effectively offering a 90 months' shelf life. Under this arrangement, the canula would be collected by the supplier after 30 months and replenished with new cannulas with a further 60-month shelf-life. Effectively giving a 90-month shelf-life within the stockpile. The original stock would then be sold by the supplier to their own customers. For DHSC a swap out represents effectively a longer

shelf life within the stockpile and a significant saving over the whole life of the contract (when compared to the cost of procuring replacement products at the end of the earlier shelf-life).

17.34 Product Cycling: by the nature of the stockpile there were items in it that were there for some time but which also could not all be cycled into the normal supply chain as they got close to expiry because the normal demand did not match the amount of product retained.

17.35 There were two broad categories of product movement: cycling product as part of the normal procurement cycle as described above or looking ahead and anticipating a degree of supply chain disruption and therefore asking PHE for permission to take inventory from the stockpile and then back fill and replenish that stock. In both cases, SCCL was concerned with value for money and had to prepare a business case which then went to PHE to be signed off before any action could be taken.

17.36 SCCL do not authorise any of the procurement decisions, it is required simply to present the business case to PHE and it is PHE's responsibility to authorise all decisions whether to go ahead or not. SCCL feed all procurement decisions from PHE to the CTSPs to instigate. A similar arrangement applied to any new items added to the stockpile. It is the responsibility of PHE to translate any government instruction into a procurement direction that can be implemented by SCCL. For example, when NERVTAG made a recommendation towards the end of 2019 for aprons to be added to the stockpile, it was PHE's responsibility to take a decision on whether or not to comply with that recommendation. In many cases, SCCL would not be aware of the recommendation, but on receipt of an instruction would look at how the products could be procured, the likely timing and value for money and then wait for authorisation from PHE to proceed.

17.37 It was never intended that the PIPP stockpile would be directly accessible for hospitals. The intention of the stockpile was to ensure a deployable depth of stock to support the supply chain to the NHS in the event only of an influenza pandemic.

17.38 All stock was held in industry standard modern logistics infrastructure which required industry standard mechanical handling equipment to access. There

were no issues reported at the Haydock distribution site of access difficulties, poor labelling or poor organisation.

17.39 I am aware of media reports during the pandemic which criticised the organisation of PIPP storage and distribution. SCCL does not consider that these criticisms are justified. One criticism, for example, was that drivers would have to wait around for long periods of time. However, it made sense to book drivers well in advance of loading times to ensure that they were present and available. In addition, more drivers than were actually needed could be booked to ensure that the unavailability of drivers was not a constraint on delivery. There were also issues loading onto Army vehicles as these are higher off the ground than standard HGVs and did not therefore fit on standard loading bays and could not take pallets from the side as with conventional vehicles.

17.40 Prior to the pandemic, the stockpile would be replenished as I have described above.

17.41 The performance of Movianto was monitored in accordance with the contract for the storage and distribution of the stockpile. The contract between SCCL and Movianto covered the management process, governance and control measures used to monitor the provision of services by Movianto all of which are dealt with in the schedules to that contract. These include details of how Movianto's delivery was monitored. However, as explained above, we are not aware of any issues with physical access to the stockpile. The Haydock site was able to dispatch over 1,000 pallets in 24 hours and where there was any delay it resulted from a lack of clarity in the demand signal not moving products.

17.42 We were very aware of issues with the clarity of the demand system and it was the most impactful issue that we faced in dealing with the stockpile. The solution that SCCL implemented was to design a demand push process, which later formed the foundation of the Clipper PPE demand push system in the Foundry IT solution. This solution was a simple morning stockpile report into the NHSE/DHSC planning functions listing all the products available to be despatched, NHSE/DHSC would then liaise with various stakeholders and report back to SCCL which products needed to be "pushed" to which delivery locations. This demand signal was received at 1830, with Movianto then picking and preparing the products overnight with delivery commencing in the

early hours of the morning. Following dispatch, a fresh stock file report was then send again to NHSE/DHSC to review allocation for the next 24 hours.

17.43 In relation to goods in the PIPP stockpile, there were none which had passed their expiry date save for those which had their shelf-life validly extended.

18 EU Exit Stockpile

18.1 In 2019, at the request and upon the instruction of the DHSC, SCCL procured a defined list of products and quantities that were to be used in the event of disruption following a no-deal exit from the EU in the expectation that there might be delays in getting products into the UK as a result of, for example, customs delays at ports. SCCL was the purchasing entity but had no role in deciding what or how much went into the stockpile. SCCL was responsible for cycling the products through, which means putting them into the main system and purchasing replacement stock (in a similar manner to that set out in paragraph 17 above).

18.2 The stockpile was put in place to address concerns about the implications of a "no-deal" exit from the EU and was co-ordinated by the DHSC and consisted principally of products that had to come into the country via the EU. Products that came from outside the EU were considered less vulnerable to the effect of a no-deal. The intention was to hold approximately six weeks' worth of stock of all the relevant products. The majority of the stockpile was situated outside of the core NHS Supply Chain network in one of two sites in the North-West.

18.3 Following the election in November 2019, SCCL were instructed by the DHSC to decommission the stockpile and all of the infrastructure that went with this was also removed. This included the National Supply Disruption Response team which had been set up to co-ordinate the response and advise on priorities in the event of shortages. At PBW12 [INQ000492083] I am attaching a copy of a letter dated 31 January 2020 from Steve Oldfield, the Chief Commercial Officer at the DHSC to 'colleagues' confirming that "*there is no longer a request from the Department to maintain stockpiles built up ahead of a potential 31 January 2020 EU exit*". SCCL were also instructed to cycle the stock through its BAU operation rather than ordering further products from the relevant suppliers. SCCL did not provide any advice on the logistics or management of the stockpile or how it should be decommissioned other than as set out above.

18.4 A review had just been initiated into what would be needed ready for January 2021 when Covid-19 hit. At that point, there was a clear direction from senior officials within DHSC that the stockpiles should be used as part of the Covid-19 response. Again, SCCL did not provide advice on the logistics or management of the stockpile as part of the Covid-19 response other than set out above.

19 Position Going Forward

19.1 Essentially NHS Supply Chain's responsibilities have returned to those that it had before the pandemic. Since April 2023, it has been responsible for the management of the disposal of excess PPE on behalf of, and under direction from, the DHSC and continues to manage additional warehouse and logistics contracts required as part of the aftermath of the pandemic response. Otherwise, however, we have largely reverted to our pre-pandemic BAU model.

19.2 Whilst we have largely reverted to our pre pandemic BAU model providing clinical consumables and medical devices to acute NHS Trusts, from April 2023 we took over management of the PPE portal which can be accessed by primary care providers (such as doctors, dentists and pharmacies). However, since the provision of free PPE came to an end, demand through this route is significantly reduced from levels seen during the pandemic as those customers have tended to return to their previous supply chains.

19.3 At various points both during the pandemic and in its aftermath, the executive team at SCCL have considered the extent to which NHS Supply Chain might work differently in the future whether to prepare for a future pandemic or to respond were a pandemic to occur.

19.4 That has involved considering both internal changes (i.e. those that lead to changes in our working practices) and external changes (those that reflect more systemic changes). I note that the Inquiry has asked for copies of the key review or lessons learned documents which underpin the table below. There are no other documents as the table was the output from the internal review and consideration which took place over a number of months and was discussed in executive or other meetings. The table below was originally a free-standing document representing the final output of those discussions. The table therefore represents the documentation relating to lessons learned.

19.5 We understand that, as part of the planning work for future pandemics currently being carried out by the DHSC/NHSE the majority of these points are being addressed by them for future plans.

Area	Issue	Suggested Approach
Governance	The responsibility for supply chain delivery was not clear as the type of pandemic (COVID) was not what was planned for (flu). This complicated the process for decision making.	The responsibility for supply chain delivery should be agreed and clearly understood by all stakeholders (DHSC/ NHSE / UKHSA). The decision-making framework should be set out as part of pre-pandemic planning so it can be impacted immediately.
Planning	The response requirements to the COVID pandemic were not defined, requiring governance and supply chain solutions to be developed "in flight".	A pandemic plan should be developed and agreed across all stakeholders. The plan should include pre-pandemic and pandemic activities and provide the "break glass" manual that is used in the event of a pandemic. To ensure the plan remains current and deliverable it is recommended there is an end-to-end test on an annual basis.
Range of responses	The pandemic plan in place was specifically for flu and based upon a reasonable worst-case scenario. As a result there were insufficient product quantities and types to meet the COVID requirement.	Future pandemic plans should provide the ability to respond across a range of pandemic types and the reasonable worst case planning assumptions updated.
Customer Base	The scope of the customer base for the pandemic response was not sufficient to meet the requirements	Future pandemic plans should include Health and Social Care requirements with agreed delivery locations and frequency built into the plan.

	of COVID – over 58k delivery locations have been delivered to.	
ICU / other non- PPE consumables	The pandemic plans did not include a stockpile or logistics solution for the deployment of ICU consumables.	Future pandemic plans should include ICU and other non-PPE consumable products.
Hospital Capacity	There was insufficient capacity within hospitals to cope with COVID patients.	Future pandemic plans should include the stand up of additional capacity (Nightingales), setting out in advance the locations, the process, the funding, the methodology and the trigger points.
Procurement	Just in time contracts to provide pandemic consumables did not fully deliver due to border closures.	Future pandemic plans should be based upon the rapid stand up of UK manufacturing to meet the requirements for all PPE where the pandemic stock holding level is less than 100% of the modelled pandemic requirement (plus safety stock).
Demand Management	Demand management was not able to be effectively implemented leading to NHS Supply Chain systems being overwhelmed by customer orders for non-PPE products.	Future pandemic plans should set out the demand management parameters that will be implemented to ensure prioritisation of PPE and other critical product supply. System development is required to enable demand management rules to be quickly and effectively implemented – in flight through the core technology refresh programme.
Inventory	There is no end-to-end visibility of inventory, including stock holding levels in Trusts.	Improved visibility across systems including in Trust inventory should be implemented to enable effective supply and demand management.

	As a result product will have been pushed to locations that did not require it.	

19.6 There are 3 additional issues which we set out below relating to:

19.6.1 Trusts;

19.6.2 Communication; and

19.6.3 Internal Changes

19.7 The following are a list of NHS Trust related issues that our discussions identified:

19.7.1 more structured customer communication forums;

19.7.2 dedicated regional resource for pandemic situations with the rest focussed on business as usual;

19.7.3 the need to have clear visibility of a main point of emergency contact and updated customer details (delivery locations etc) for each customer;

19.7.4 the need to be very clear with customers on decision making rationale. By this I mean any decisions that are likely to have an impact on customers such as stock availability. This builds credibility but also stops a flurry of unnecessary questions and activity;

19.7.5 the need to collaborate with customers and encourage collaboration between customers: our mutual aid activity (getting them to share PPE as necessary) went down very well in a very difficult time.

19.8 We also identified further Communication issues:

19.8.1 move quickly to more frequent, transparent (where possible) communication with all stakeholders both internal and external replacing the more ad hoc communications of the past;

19.8.2 where necessary, recognise new people/stakeholders need education on what we can do and what we can't do – lots of new people on the scene in very short order, often with little information;

19.8.3 establish key data feeds of information quickly e.g. PPE levels shipped; and get hold of key data feeds from other areas to allow accurate decision making;

19.8.4 change operating hours, recognise the need for 7 day coverage, move to rota, prioritise day job rather than exhausting the current team;

19.8.5 recognise and address the challenge of conflation between, for example, the supply chain of the NHS (which involves a number of participants and the NHS Supply Chain for which we are responsible) so that stakeholders understand the extent and scope of our role.

19.9 We have also identified some internal changes that we have started to implement. We imagine that these will be of less immediate interest to the Inquiry team but we are, of course, very happy to provide more details if that would be helpful. Some of those include the points set out below.

19.9.1 We are developing a pandemic "play book" as part of our wider business continuity work (which now looks at what we might have previously considered to be more "far-fetched" scenarios). This will be more of an 'internal-facing' document but will cover how we better resource our response whilst still allowing for business as usual work to continue. We have already looked at creating greater levels of capacity within the management team by separating out operational matters from the day-to-day management of the business.

19.9.2 We have revised the operating model for the NHS Supply Chain to bring back in house the procurement of medical products. Whilst

not the sole reason for this change, the ability to greater control who buys what in an emergency situation was a factor in making that decision.

19.9.3 Our operating model now places a greater level of focus on the resilience of our supply chain to ensure that, to the extent possible, we are not reliant on a small number of suppliers for key products and understand how we react if issues arise. A category strategy will address supply chain resilience issues for that category of products so that we are less reliant on one particular supplier or one particular region of the world. Since most of our procurement activity has now been insourced the responsibility for developing the category and sourcing strategies is the responsibility of SCCL.

19.9.4 The need for our record keeping to capture as much real time information as possible so that we have full records of decisions made (at a time when teams are under pressure to move quickly) and we have audit trails of products purchased, quantities and payments. This will help ensure that we can respond to the significant number of queries that come from interested stakeholders both during a similar event and afterwards. This ties back to the inventory management which I refer to in the second part of my Rule 9 response.

19.9.5 In addition, we have recognised the need to significantly increase the speed of our IT systems modernisation.

Statement of Truth

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

Signed: PD

Dated: August 2024 19 August 2024