Witness Name: Stephen Barclay
Statement No.: 1
Exhibits: SB/5/001 to SB/5/047
Dated: 14 February 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Rt Hon Mr Stephen Barclay

I, Stephen Barclay, will say as follows: -

1. I make this statement pursuant to a Rule 9 request from the UK Covid-19 Inquiry in relation to Module 5 dated 8 September 2024.

2. From 13 February 2020 to 15 September 2021, I served as Chief Secretary to HM Treasury ("CST"). For the duration of the period that is within the scope of the Inquiry, I also served as Chancellor to the Duchy of Lancaster (15 September 2021 to July 2022) and then Secretary of State for Department of Health and Social Care (from 5 July to 6 September 2022 and 25 October to 13 November 2023).

3. I have developed the below statement based on my personal recollection of events and the decisions that I took and with assistance from His Majesty's Treasury ("HMT"), key documents are exhibited to this statement.

4. In relation to documentary material, as I have stated previously to the Inquiry, during the period of the Covid-19 pandemic I did on occasion communicate with colleagues by WhatsApp and as requested I have previously provided these to the Inquiry.

Role of CST

5. The CST is a ministerial office within HM Government and the second senior ministerial office in HMT, reporting to the Chancellor. The CST is responsible for public expenditure, which includes the following areas of most relevance to this module:

(1) Spending reviews and strategic planning
(2) In-year spending control
(3) Public sector pay and pensions
(4) Efficiency and value for money in public service
(5) Procurement

6. The day-to-day duties of the CST involve interdepartmental and Treasury meetings, stakeholder engagement, budget management, and policy development. Additionally, the CST has decision-making authority, including approving budgets and influencing economic and fiscal policies, all under the guidance of the Chancellor.

7. HMT utilises procurement principles and regulations which are codified in the document Managing Public Money ("MPM"), which sets out the main principles for dealing with resources in public sector organisations in the UK. Additionally, the CST receives advice from HMT's policy advisors on procurement and payment requests, along with recommendations on whether the requests should be approved. This guidance forms the basis on which the CST makes decisions. Key decisions and actions that I undertook during the relevant time will be described later in this statement.

8. I was not involved in the appointment of Lords Agnew, Bethell, Deighton, Feldman nor Baroness Harding. I am not aware of who made the decision to appoint other than I presume No 10.

HMT's role in relation to procurement

9. During the relevant time, HMT's role was on overseeing public spending was often delegated to AOs given the urgent pace at which decisions were required. This was particularly the case to ensure rapid procurement of healthcare equipment and supplies. HMT only approved spending for major projects, novel or contentious spending, or expenses beyond a department's authority limit. It did not manage the internal allocation of a department's funds.

10. HMT officials were involved in various cross-government boards, such as the PPE Oversight Group and Senior Assurance Meetings, to address procurement issues for healthcare supplies. It also participated in the Ministerial Implementation Groups

(MIGs) and other committees to coordinate the government's pandemic response and ensure departments were informed of economic developments and spending controls.

11. The COVID-19 pandemic required HMT to support quick and significant financial decisions for health and care systems in a fast-moving market and uncertain environment. It needed to balance public spending principles with the flexibility required to meet the urgent health response spending.

12. HMT aimed to: maintain value for money; act rapidly to support public health outcomes; and consider the health of the economy. It reminded departments of their duties to ensure value for money and proper spending processes during the pandemic.

13. HMT applied flexibility to its spending principles during the pandemic by:
    - Giving more control to departmental Accounting Officers (AOs), allowing for faster and more flexible emergency spending responses on the basis that AOs were expected to maintain spending standards.
    - Allowing more generous spending limits and authority delegation than would normally be the case to support rapid decision-making.
    - Responding swiftly to spending requests, often within hours.

14. HMT's approach shifted through three overlapping phases:
    - Phase 1 (March-May 2020): With an overriding priority on health outcomes, HMT supported emergency spending with a higher risk appetite due to the urgency of the situation, accepting trade-offs like higher costs for healthcare supplies as the alternative could have been loss of life.
    - Phase 2 (May 2020-April 2021): As the pandemic progressed and costs rose, HMT focused on delegating increasing budgets to AOs as the initial emergency sign off processes were not effective as a longer term position given the asymmetry of information between departments in part DHSC and HMT.
    - Phase 3 (April 2021-October 2022): HMT built on previous learning, managing spending peaks more effectively with less acute trade-offs between taxpayer and patient interests, and preparing for a return to pre-COVID spending arrangements.

15. Throughout these phases, HMT faced challenges such as the need for quick decision-making, dealing with uncertainty, and incomplete information. It accepted these

challenges by delegating significantly more authority to AOs. HMT evolved its response to these challenges while maintaining adherence to the principles of the MPM framework, ensuring responsiveness to health and care needs while delivering value for money. HMT reminded departments of spending rules, including regarding fraud as well as the need for approvals for indemnities, and worked with DHSC in particular to highlight these issues.

Devolved Administrations

16. The UK's Devolved Administrations ("DAs") in Scotland, Wales, and Northern Ireland receive multi-year funding settlements determined by the Barnett formula, with adjustments for specific policy areas. They have their own tax and borrowing powers. HMT does not directly approve DA spending on health and care, but some vaccines and medicines are purchased centrally with HMT approval.

17. In 2020-21, DAs received an in-year funding guarantee to manage the pandemic, initially set at £12.7 billion and later increased to £16.8 billion. From 2021-22, COVID-19 funding was included in Spending Review settlements, so no further guarantee was needed. Health and care policy remained devolved during the pandemic.

18. For civil emergencies, Chapter 8 of the Statement of Funding Policy outlines how DAs can access the UK Reserve in exceptional circumstances. DAs must submit a ministerial letter to the CST to make their case. The Statement of Funding Policy reflects agreements with the DAs:

- Scottish Government: The Fiscal Framework allows borrowing up to £3bn for capital and £1.75bn for resource purposes, with a £700m Scotland Reserve. Limits will increase from 2023-24 using the GDP deflator.
- Welsh Government: The Fiscal Framework includes a needs-based factor in the Barnett formula, allowing borrowing up to £1bn for capital and £500m for resource purposes, with a £350m Wales Reserve.
- Northern Ireland Executive: No formal Fiscal Framework, but agreements include £3bn capital borrowing under the Reinvestment and Reform Initiative and adjustments for long-haul Air Passenger Duty devolution.

19. UK ministers had very little visibility as to how covid funding being used by DAs as there was no requirement for them to provide detailed data on areas that were devolved and so subject to their authority. HMT did respond constructively for requests for flexibility, for example taking the unprecedented step to allow unspent Barnett consequentials to be included in in-year transfers.

My role as CST in relation to procurement

20. I provide below a chronological summary of role in relation to the procurement of key healthcare equipment and supplies during my time as CST. I worked with various ministers and government departments during the course of my role, of which specific instances are detailed in the chronology.

March 2020:

Early into the pandemic on **22 March 2020**, I received advice from my officials that DHSC's Secretary of State had approved the purchase of $20m PPE from a Chinese provider called Meheco. I was recommended to approve the purchase on a one-off basis. However, I was not recommended to agree to a larger amount of £100m for PPE until the department had had time work through further concerns [SB/5/001][INQ000572255]. In response to this, on **23 March** my office emailed DHSC to express my deep discomfort with the apparent lack of due diligence that the products being bought were safe. However, given that we were told that there was only two weeks of stock remaining, I felt that there was no option but to approve the request at that stage. We were advised by DHSC's Accounting Officer that they were confident that the purchase was consistent with the requirements of MPM [SB/5/002][INQ000507646].

On **24 March**, I subsequently received Advice that DHSC sought approval to pre-order I&S m testing kits for £75m. I was recommended to approve the order, given the government's current objective to rapidly expand testing, and I did so the same day. However, I requested a detailed breakdown from DHSC on what demand modelling showed we would need against the supply curve of what equipment and staffing would be in place. [SB/5/003][INQ000572260] HMT was again told this order was urgent and there was insufficient time for scrutiny hence the retrospective request for demand modeling rather than in normal time demand modelling being provided first.

The following day, **25 March**, I approved a request from DHSC for approval of payment totaling $19,390,000 for face masks and eye protectors as well as approval for discussions between HMT and DHSC on setting up a delegated funding envelope for ventilators and all linked purchasing, PPE purchases and home testing kits, with the aim of preventing last minute approvals being submitted with minimal time to provide advice and consider [SB/5/004] [INQ000477810]. That same day, the department also received another urgent request from DHSC, this time for a payment of $745,000 for goggles, face masks and FFP2 face masks. My officials recommended that I approve this payment, which I did [SB/5/005][INQ000572257]. I recall that on two occasions during this period, the need for urgent decisions often within the matter of hours was also shaped against the backdrop of two complaints from No 10 to HMT suggesting that either HMT officials or ministers had delayed decisions or time critical procurement following statements made by DHSC to No 10 directly. When investigated by HMT officials on both occasions the request had not been made and as a result no referral had been made from official to minster. While this was quickly cleared up at the time it reinforced expectation from No 10 and DHSC that decisions would be taken to a very expedited timeline.

April 2020:

The following month, my decisions were sought on several issues, including testing and FCDO procurement. On **17 April**, I was sent advice on options to evolve the delegated fund that I had approved on **25 March**. The original fund was set up to allow DHSC to make advanced payments in the competitive market for testing at the beginning of the pandemic. To ensure DHSC had available funding for all components of their testing programme, we put forward two options: (1) HMT maintained all approval on DHSC spend relating to testing, or (2) provided a ring-fenced budget of funding for a 3/4-month period. Managing Public Money rules would still apply. My officials recommended the second option, to ensure that full accountability for all spending relating to testing rested with DHSC. On **23 April**, I gave my approval to this option [SB/5/006][INQ000572249].

Prior to this, I also approved a request for £191m, as part of the Health Secretary's aim to increase capacity to 100,000 tests per day as part of Pillar 1 of testing capacity on 20 April [SB/5/007] **[INQ000574010].**

Separately on **18 April**, FCO, CO and I received a request from the SoS DHSC for design of a protocol in which FCO posts could directly authorise the purchase of urgent

PPE stocks [SB/5/008] [INQ000574011]. On **20 April**, I confirmed that I accepted the proposed approach as long as all PPE kit was checked in the UK to ensure it is safe for the intended use before it goes to the NHS front line; any kit that is rejected is notified to HMT within 24 hours and action is undertaken to recover payment; the simplified checklist for Ambassadors closely mirrors HMT conditions; DHSC's AO will be responsible for ensuring that this protocol delivers outcomes in line with HMT conditions; the protocol set out by DHSC includes a reporting requirement intended to ensure that DHSC continue to report against the overall envelope and against HMT conditions; the approach has been agreed with the Chief Commercial Officer of NHSE and is supported by DHSC's AO.

May 2020:

On **12 May**, I received correspondence from the DAs requesting my support for funding of their costs incurred in purchasing of PPE due to concerns about limited supplied being delivered through UK wide approach [SB/5/009] [INQ000574005]. DA finance ministers and I held a call on **19 May** and further discussion was held concerning PPE spend and how it was to be funded, using the Barnett formula approach or UK wide. The DA finance ministers expressed frustration that they considered that the "Four Nations" approach was not working in practice [SB/5/010] [INQ000574006].

June 2020:

On **18 June**, I was informed that DHSC was requesting approval to enter into a long-term domestic PPE manufacturing contract with Medicom Healthcare B.V. The total value of the contract would be £307,620,000, of which £90.5m would be covered by the 2020 envelope but £217.1m would count as new PPE spend. The contract would provide I&S m facemasks and I&S m respirators. My officials recommended I approve this deal, as it would ensure PPE supply at a reasonable price and provide a stockpile in case of a second wave [SB/5/011][INQ000572238]. I reluctantly accepted the recommendation that day with significant reservations setting the following conditions as a result but with the following conditions: 1) DHSC provide timelines on when negotiations began with Medicom, 2) the location of any Wales site be agreed with SoS Wales and 3) Chancellor of the Exchequer's office will raise again the issue of the failure of data being shared with HMT in a timely manner [SB/5/012][INQ000528097].

July 2020:

On **16 July**, I sent correspondence to SoS DHSC expressing my concern that various public sector bodies were claiming for legitimately purchased PPE due to lack of supply

from DHSC. I requested that DHSC provide this funding retrospectively to those affected [SB/5/013][[INQ000573996]. The SoS responded to my concerns on **28 September** setting out the process for bodies to claim retrospective disbursements and for onward supply of clinical grade PPE between August 2020 and March 2021, for needs arising from Covid 19. DHSC asked bodies to complete Impact Assessments to provide detail of the demand and costing, which would form the basis for Memoranda of Understanding between DHSC and each body. Primary care, social care settings and essential public health services were to be supplied directly via the PPE portal, with other bodies being supplied via a direct push from DHSC. The SoS confirmed that DHSC had expanded access to the PPE portal to ensure a continuous supply of free of charge PPE in all social and primary care settings [SB/5/014][[INQ000574007].

October 2020:

On **31 October**, I received correspondence from the Scottish Cabinet Secretary for Finance expressing concern about the discontinuation of the VAT relief for the purchase of PPE, as the reduced VAT was due to end that day. It was felt that the DAs had not been consulted nor impact been considered, impacts that would be significant [SB/5/015][[INQ000574008]. The First Secretary of the Treasury ("FST") leads on VAT matters and so my office forwarded the correspondence to them [SB/5/016][[INQ000574012]. as was subsequent correspondence from the Welsh and Northern Irish finance ministries [SB/5/017][[INQ000574009].

November 2020:

On **13 November**, I received a request from DHSC to provide £50m of cover to deal with oversupply of PPE items. This was to enable the 'turn off' of supply in certain categories (e.g. face visors), following assessment that initial assessments about reasonable worst-case scenarios had not come to pass and even with an uptick in infections these were now over stocked. The case was made that the shelf life of these products would expire and lead to a whole cost write down. I was recommended to approve this cover [SB/5/018][INQ000572258]. However, I was not content to provide DHSC with approval at this stage and expressed deep reservations as to how it had been dealt and as result on **18 November**, I requested a full breakdown of the surplus stock and the full end to end cost per item, as well as a range of other broader questions about other DHSC programs, warehouses, and storage, and whether DHSC were notifying the NAO [SB/5/019][INQ000477831].

December 2020:

Following my rejection on **18 November**, I received a second submission on **9 December** addressing the queries and concerns I had with the initial submission. This included supplying a breakdown of the value of PPE, plans for a lessons learnt exercise and continued monitoring and involvement of the NAO. I was again recommended to approve this spend [SB/5/020][INQ000572259]. I did so on **16 December**. However, I made several changes in the letter informing DHSC of the decision which focused on communicating that HMT conditions were not met, for example no action seemed to be taken regarding demand modelling [SB/5/021][**INQ000574000**]. That same day, I sent a letter to the Secretary of State for Health and Social Care and the CDL setting out my reluctant approval to the spent and highlighting a number of concerns I had with the process, for example around supply/demand modeling, the risk to PPE stock and a broader point about retrospective spending approvals [SB/5/022][**INQ000574001**].

Prior to this on **1 December**, my office received advice relating to a request from DHSC for the retrospective approval of £184.5m for warehousing and storage of PPE items which would be covered by the existing Freight and Logistics envelope. This was considered to reflect reasonable value for money and was a necessary expense, and so I was advised to approve this spend [SB/5/023][INQ000572256]. However, this request was not sent to me until **16 December** to gain input from Lord Agnew beforehand [SB/5/024][INQ000572250]. On **25 January**, I confirmed that I was unwilling to approve this retrospective spend. As with other areas, the position was to provide budget cover but leave the spend as irregular based on the fact it was a retrospective request [SB/5/025][INQ000477873].

On **16 December**, DHSC sought retrospective approval from me to approve a £496.2. spend with Uniserve as part of a logistics contract for the import of PPE. My officers advised that this be approved subject to DHSC addressing comments from Lord Agnew. The alternative was to leave the spend as irregular, which was in the context of wider non-approval of retrospective DHSC spend, however in this case my officers felt that approval was justified. On **25 January** I informed DHSC that I was unwilling to approve this retrospective spend. As with other areas the position was to provide budget cover but leave the spend as irregular based on the fact it was a retrospective request.

January 2021:

On **20 January**, I received a box containing submission relating to DHSC spending, requesting that I approve £13bn for PPE and £400m for ventilator purchases as well as additional spend on testing and vaccines. This is against a wider background of DHSC unapproved spending [SB/5/026] [INQ000477872]. I responded to this on **21 January**, and agreed with the position from officials that HMT should provide DHSC with budget cover of the overspend in order to protect front line services, however I would not approve the spend to ensure it remained irregular. I insisted that the spend be classed as irregular as I thought it should be brought to the attention of NAO due to my wider concerns as to the pattern of behaviour of last minute or retrospective requests combined with inadequate transparency on data [SB/5/027] **[INQ000574002].**

April 2021:

On **1 April** I sent a letter to the Treasury Select Committee relating to the investigation into government procurement during Covid-19. The letter laid out my overview of spending controls across many areas including PPE procurement. I set out my concerns with regard to sub-optimal contracts and explained the measures taken to mitigate them [SB/5/028] **[INQ000573997].**

June 2021:

On **4 June**, DHSC requested £60.6m to extend the Milton Keynes Lighthouse Lab contract until March 2022. As the lab accounted for 25% of Pillar 2 testing capacity and was seen as good value for money, it was recommended that I approve, and I did so on **8 June** [SB/5/029][INQ000572239].

Previously on **27 May** I received a request from DHSC for approval to run 2 mini-competitions for supply of Lateral Flow Devices for Test and Trace totaling £1.2bn. I was advised to approve the first competition only and require further approval for the second. I initially refused the request on **3 June** due to value for money concerns. However, on **4 June**, to avoid delaying the procurement, I agreed to fund the initial competition as per the advice given to me, but I continued to stress that I was unhappy with the effectiveness of the programme [SB/5/030] **[INQ000572251].**

On **17 June**, DHSC requested £149.3m for the provision of Home Antibody Testing Services provided by Thriva. As the contract extended into the 22/23 financial year

(which Test and Trace had no budget for), I was advised to approve only the 21/22 spend at £75.5m. DHSC would then need to seek approval separately for any spend ahead of the 22/23 financial year [SB/5/031] **[INQ000574003].** I agreed to this request the next day [SB/5/032][INQ000572252].

On **18 June**, DHSC sought £145m for a 4-month extension of the Rapid Testing Fund. This related to the costs associated with the administration of LFT's in care homes i.e., staff time overseeing testing of visitors, the processing and logging of results. The recommendation was that I approve an extension of 3-months only, as per advice from the Infection Control Fund. I approved this on **21 June** [SB/5/034] **[INQ000574004].** Additionally, DHSC requested approval for £482m to spend on PCR reagents and consumables for Pillar 1 and Pillar 2 testing labs. The contract was highly flexible, with the company altering supply based on DHSC forecasts, so there was little risk of over- or under-procurement. It was recommended that I approve this request and I did so on **21 June** [SB/5/035][INQ000572253]. On the same day, I also received a submission for £75m to extend the REACT Covid Prevalence Survey by one month. I was advised to approve this due to the need for robust data and support of senior scientists [SB/5/036][INQ000572240]. I confirmed my approval one week later [SB/5/037][INQ000572241].

On **25 June**, DHSC requested approval to spend £84.7m to ramp up PCR testing capacity across seven Pillar 2 labs for 8 weeks. This came in response to short term PCR testing constraints. It was recommended that I approve this request. I was conscious of the need to procure some additional capacity but wanted further information to determine whether uplifts to all labs were really needed. Therefore, on **28 June** I requested additional information in the form of forecasted demand and supply for PCR capacity between June and September. In response, I received additional information that revealed that demand for testing was already exceeding 70% of lab capacity and was expected to surpass 80% by mid-July, threatening turnaround times due to the inability of labs to recover from high demand. With no margin for additional increases and turnaround times at risk, the advice given to me was not to delay mobilising labs despite the potential for minimal savings. Furthermore, the risk of longer turnaround times affecting contact tracing and increasing infections as restrictions ease could lead to public criticism. Consequently, it was recommended that I approve the capacity increase for all seven labs, which I did on **29 June** [SB/5/038][INQ000572242].

July 2021:

After the 1st tranche of LFD tests was approved on **4th June**, a submission for the 2nd tranche was raised on **16 July**. I raised concerns as I had previously voiced my scepticism about over-reliance on LFDs. I received the request on Friday **16 July** at midday, and on Tuesday **20 July**, I was told that without approval stocks would run out and on that basis I agreed. I also confirmed that I would deal with monitoring and planning tasks in due course. I understand that Jenny Harries raised the LFD request with the PM over the weekend of 17 – 18 July and expressed the view that I was sitting on an approval. However, I believe this to be inaccurate. DHSC provided a business case to my officials at midday on Friday and it was subsequently agreed that this would be processed by the 23rd July [SB/5/039][INQ000572243]. HMT routinely turned business cases around in 24hrs or quicker in case of urgent need, but at no point until the evening of Sunday 18 July was it made clear that this required such turnaround [SB/5/040][INQ000572244].

Additionally, on **20 July**, Test & Trace sought approval for an additional £69m to support the domestic manufacture of SureScreen LFTs. It was recommended that I approve this request, as it would increase diversity of supply and lower the per unit cost, which I did so on **23 July** [SB/5/041][INQ000572254].

On **23 July**, DHSC sought approval for £339m to increase PCR capacity by 152,000 per day for 12 weeks in response to higher coronavirus prevalence. It was recommended that I approve this request. I agreed with the need to increase capacity but questioned the significant sums of money involved in achieving this. On **27 August**, I asked for further assurance that this increase was needed, particularly in the wake of increasing numbers of double vaccinated in the population. In response, DHSC advised that the original request was to procure up to a level that would enable testing capacity to hit 152,000 per day. The final cost would depend on the number of tests used, so if demand was less, the overall cost would similarly decrease. In short, the contract enabled DHSC to procure the option of surge capacity in testing, rather than committing to buy surplus tests that may never be used. As a result, I agreed to the original contract on the same day [SB/5/042][INQ000572245].

On **30 July**, DHSC requested approval for a special payment of £ I&S to terminate a contract of £5.9m with Hutchinson Ltd for PCR test kits and consumables. This contract

was one of seven already agreed and if not cancelled it would lead to significant wastage of excess PCR kits and consumables. I was recommended to approve this payment, as terminating the contract at this earlier stage would prevent DHSC becoming liable to pay the full contract value and, thus, minimise losses. For this reason, I approved the payment on **2 August** [SB/5/043][INQ000572246].

August 2021:

On **24 August** I received two pieces of advice. Firstly, I was advised on the approval of an advance payment of £263,000 to Adreco Ltd for I&S cassette tools. These tools would enable the company to produce plastic injection molded antibody testing kits on a greater scale. The recommendation was that I approve this payment.

The second piece of advice related to rule changes that were made in November 2020. Due to the large number of advance payments being requested at that time, I had agreed to delegate these approvals to SCS, if the payment value was less than £10m. By August 2021, the expectation was that HMT would receive many fewer requests and so it was recommended that delegation to SCS should cease. I confirmed that I agreed with both recommendations on **26 August**.

On **27 August** I was advised on the approval of an advanced payment of £57,557.50 to Extrupol Packaging. The payment would ensure supply of waste liners to the Rosalind Franklin PCR laboratory, thus allowing testing workflow to continue and maintain staff safety. As this was a relatively crucial component in the proper functioning of a key PCR laboratory, the recommendation was to approve this payment, which I did on **1 September** [SB/5/044][INQ000572247].

September 2021:

On **3 September** I was advised on proposed changes to the Test, Trace, and Isolate policy. I was provided with a table outlining these changes [SB/5/045][INQ000572248] [SB/5/046] **[INQ000573999].** These included continuing funding for widespread self-testing for asymptomatic NHS and social care staff, staff in high-risk workplaces, and extending testing in schools until the October half term. UKHSA also recommended extending the legal duty and practical support for self-isolation until March 2022, offering daily contact testing to any member of the population who is an unvaccinated close contact of a positive case, and strengthening communications around the use of the NHS Covid-19 App over the autumn and winter. On 6 September, I confirmed that

I agreed with all recommendations outlined in the table, however I was of the view that universal testing should have a clear exit strategy with a move to private testing. In the meantime, I approved the purchase of 208m LFDs to avoid winter shortages, on the understanding that the policy on universal testing had not been fully finalised [SB/5/047][INQ000477883].

Steps taken to eliminate fraud and the prevalence of fraud

21. Whilst HMT is responsible for setting the framework and guidance for managing fraud risk in conjunction with the Cabinet Office, it does not have a formal role under the MPM guidelines to manage fraud in departments. During the COVID-19 pandemic, HMT reminded departments of spending rules and adjusted approval levels to enable swift decision-making. It provided guidance on using temporary spending framework flexibilities for emergency responses.

22. Concerns arose over DHSC's lack of inventory records, affecting the assessment of potential fraud-related losses. HMT worked with DHSC to improve their procedures and recommended enhancements for stock monitoring.

23. In the pandemic's early stages, DHSC signed contracts with indemnities prior to clearance by HMT even though they had not been given authority to do so. As HMT was therefore left with no choice but to approve these contracts retrospectively and emphasize the need for transparency in contract signings to the Health Secretary. HMT also followed up with DHSC to ensure compliance with a request from the Public Accounts Committee for a plan to manage excess PPE stock.

24. As key parts of the budget had been delegated to DHSC HMT officials advised that fraud controls were a matter for DHSC AO with oversight from CO rather than for HMT directly. This was supported by the significant interest of Lord Agnew took in challenging DHSC regarding concerns with fraud.

Compliance with public law procurement principles and regulations

25. During the COVID-19 pandemic, HMT had to adapt its MPM principles to enable DHSC through increased delegated authority to swiftly procure vital PPE and healthcare

equipment, balancing taxpayer interests with urgent health needs. Some usual procedures were altered for expediency, with senior officials overseeing these exceptional decisions. Contracts were largely negotiated in short and sometimes incredibly short timeframes, and significant areas of procurements went through the Treasury Approvals Process (TAP), which is typically used for significant, novel, or contentious spending. Due to the urgency and volume of COVID-related spending, HMT bypassed TAP panels, instead setting conditions and relying on officials through informal meetings to monitor expenditure. For PPE procurement, TAP was not used; rather, official led meetings were held to oversee spending, although data limitations led to reliance on modelled data and resulted in large PPE stockpiles. HMT imposed conditions on flexible procurements, such as requiring a Crown Representative's confirmation, and has reverted to standard procedures for any ongoing supplier relationships for re-procurement.

26. Very late requests with significant information asymmetry and often parallel lobbying through No 10 with, in some instances, no approval sought before commitments were made and requests then being retrospective, were a source of significant frustration. Very large spending decisions were often required out of hours to very tight deadlines where the clear message was that without approval loss of life would result from gaps in equipment to protect staff or our ability to treat patients. There was also a very strong steer from No 10 that in weighing the balance between spending control and timely delivery, HMT was expected to ensure contracts were not missed to international competitors due to delays in assurance processes.

Conflict of Interests

27. In order to help mitigate and manage conflicts that may otherwise create material or perceived risk to the department, all HMT officials must declare all relevant conflicts of interest in line with the Civil Service Code, HMT Values and the Propriety and Ethics Guidance. Senior management oversee this, and the Permanent Secretary is ultimately accountable.

28. The August 2019 version of the Ministerial Code applied at the time of the pandemic and set out the code of conduct and requirements for Ministers and the general principle: '*Ministers must ensure that no conflict arises, or could reasonably be perceived to arise, between their Ministerial position and their private interests, financial*

or otherwise.' On appointment, the Code required HMT Ministers to provide a declaration of any private interests that might give rise to a conflict.

29. These key processes and procedures for officials and Ministers remained in place during the pandemic and were effectively implemented according to the codes and guidance.

30. With regard to lessons learned, a key challenge in was lack of timely information, the information asymmetry of what requesting department was aware of compared to the information available to the HMT and the paper based way in which Whitehall operated with little use of technology. There was limited access to subject matter experts and a culture where transparency within government was often limited as primacy was placed on securing HMT approval rather than developing a shared understanding of the issue.

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 of its truth.

Signed **Personal Data**

Dated: 14 February 2025