Witness Name: Dr Beverley Jandziol

Exhibits: 229

Statement No: 1

Dated: 31 January 2025

THE UNITED KINGDOM COVID INQUIRY

FIRST WITNESS STATEMENT OF DR BEVERLEY JANDZIOL

I, **DR BEVERLEY JANDZIOL**, **WILL SAY** as follows:

A. INTRODUCTION

1. I make this statement in response to the request by letter dated 30 September 2024 for evidence under Rule 9 of the Inquiry Rules 2006 made on behalf of Baroness Heather Hallett, the Chair of the UK Covid-19 Inquiry ("the Inquiry"). By this statement, I set out my involvement in public procurement of key equipment and supplies across the UK public sector in relation to the Covid-19 pandemic and the onwards distribution of key equipment and supplies, during the period from 1 January 2020 to 28 June 2022 ("the relevant period").

2. The views expressed in this statement are founded on my personal knowledge, but I have been assisted in the preparation of this statement by officials at the Department of Health and Social Care ("DHSC") and the Cabinet Office ("CO"), GLD and Counsel and by referring to documents which have been made available to me by them.

3. During the relevant period I used my CO email address from March to mid-July 2020 and then a DHSC issued laptop from mid-July 2020 to December 2020. This means that correspondence relating to antigen Lateral Flow Tests ("LFTs") and Operation Moonshot ("OP") will be from my DHSC email address. I no longer have access to either laptop as both were returned to their respective departments. However, officials at CO re-opened the archive of my emails in around December 2023 when I did a preliminary search of documents, and I have sourced approximately 35,000 relevant emails. I have referred to those which I believe are relevant to the issues in this statement and the matters upon which I have been asked to comment. The online calendar has not been preserved. It was necessary for me to sit at a desktop

to access it. I no longer have access to it although I have had access to a PDF extract which shows meetings in a calendar format, but I am unable to determine detail such as attendees BJA/1 - INQ000535893.

4. In this statement I exhibit documents supporting, illustrating, or providing context for matters addressed in the statement or which will otherwise assist an understanding of the matters addressed in it. I shall refer to the exhibits to this statement by "**BJA**" followed by the relevant number, each exhibit being numbered sequentially.

5. The remainder of this statement is divided into the following sections:

B. Background

C. My Appointment

D. NHS Test & Trace ("NHSTT")

E. Strategy During the Pandemic

F. My Role in Procurement

G. Industry Engagement

H. Testing Equipment

I. Laboratory Testing

J. Asymptomatic Testing

K. Procurement of LFT and PCR

L. Award of Contracts

M. Advice from Officials and Consultants

N. Overall Value of Contracts Awarded

O. Steps Taken to Eliminate Fraud and the Prevalence of Fraud

P. Conflicts of Interest

Q. Contractual Provisions and Performance by Suppliers and Manufacturers

R. Compliance with Public Law Procurement Principles and Regulations

S. Operation And Effectiveness of Regulatory Regimes

T. Decisions as to What to Buy at What Cost

U. Suitability and Resilience of Supply Chains

V. Changes to Procurement Processes

W. Lessons Learned

X. Statement of Truth

B. BACKGROUND

6. I am a procurement director with around 24 years of experience, 20 of which were within consulting and blue-chip businesses.

7. By way of summary, between 1 January 2018 to 31 December 2019, I held the following positions:

   a. As of January 2018 I was (and had been since April 2012) Client Director for Procure4, a procurement consulting firm, with responsibility for client management at executive level as well as overall responsibility for leading a team of category managers and analysts in the delivery of supply chain optimisation programmes for key clients. I had joined as a project leader and in August 2016 was promoted to client director. The role involved managing multiple teams across a portfolio of client engagements. The typical spend range per client ranged from £50m to £100m. The sectors in which I worked included hospitality, retail, healthcare, fast-moving consumer goods and construction. I held this role with Procure4 up until the end of August 2019.

   b. On 30 September 2019 I joined the Cabinet Office ("CO") as a Commercial Specialist in the Complex Transactions Team ("CTT") as part of the Government Commercial Function ("GCF"). I was a Civil Servant (grade SCS1) and therefore a Deputy Director. Within that position, in October 2019 I led the negotiation team for the Electoral Management System.

   c. From October 2019 (to February 2020) I delivered a delivery model assessment to determine the insourcing/outsourcing of the DWP Health Transformation Programme. In November 2019 (to March 2020), within CTT I critically evaluated and provided commercial assurance on the FCDO (then FCO) Project Atlas ERP Replacement.

8. By way of summary, between 1 January 2020 and 28 June 2022 I held the following positions:

a. I continued as a commercial specialist in CTT at Deputy Director level within the GCF in CO until April 2022. From 18 March 2020 until 18 December 2020, CTT was deployed to DHSC to organise, set up and deliver commercial contracts during the early set-up of Covid-19 testing ("NHSTT"). After returning from the deployment on NHSTT I joined the Senior Management Team and I also led the Accounts Team within CTT to ensure we optimised the way we engaged with our client departments. I set out in more detail below my role and responsibilities.

b. From May 2022 I have been a commercial director within the FCDO. My role is to provide senior oversight and accountability for the commercial delivery of all International Development programmes (known as "ODA"-Official Development Assistance).

9. During the pandemic (that is, between 1 January 2020 and 28 June 2022) my role and responsibilities for matters within the scope of Module 5 were as follows:

a. As I set out above, I was a commercial specialist within CTT in the GCF based out of CO. The CTT is a central commercial team which provides expert internal consultancy support on the Government's most challenging commercial issues. Client departments would pay a day rate for CTT personnel deployed on their projects, normally on a time and material basis. CTT commercial specialists were deployed across various aspects of the Government's requirements during the pandemic: initially on PPE, Testing, Ventilators and latterly vaccines. From March to December 2020 my role was as commercial specialist deployed to the DHSC Covid-19 National Testing Programme ("NTP") which became NHSTT. My background includes a PhD in Cell Biology. Given my scientific credentials and my 20 years' experience in supply chains, I was requested to act as Commercial Lead in DHSC's NTP and I undertook this role.

b. My responsibilities were an overarching accountability and oversight for the commercial aspects across all workstreams within the NTP. Those workstreams were the Five Pillars, to which I deployed commercial specialists within the CTT to lead on those Pillars. In addition, my role as having overarching oversight as Commercial Lead required me to bring together various disciplines (veterinary and medical science, industry and academia) to rapidly test, validate and industrialise new and developing solutions within testing technology. I also had to engage with and, where

relevant, develop new relationships with stakeholders including the following:

i. Ministers and their private offices including Special Advisors ("SpAds") and No. 10 SpAds and other representatives;

ii. DHSC Finance and Commercial, HMT and Legal;

iii. Supplies Director (initially Dr Samantha Roberts and later replaced by Dr Emma Stanton), Senior Responsible Owners (for example Kristen McLeod, Alex Cooper, Tamsin Berry) and Policy (e.g. Kathy Hall later replaced by Gila Sacks);

iv. Scientific leadership (including Professor Dame Sue Hill, Professor Angela Douglas, Professor Sir John Bell, Sir Patrick Vallance, Professor Sir Chris Whitty, Sir Jonathan Van-Tam) and scientists within Public Health England ("PHE") as well as additional external researchers and academics;

v. The leadership team of NHSTT including Dido Harding;

vi. Stakeholders in Other Government Departments ("OGD") e.g. FCDO (then FCO), BEIS and the NHS.

Relationship development and cross-functional collaboration across this broad spectrum was critical to enable the growth, development and sustainability of Covid-19 Testing capacity to ensure it was fit for purpose in responding to emerging and changing need.

c. In August 2020 Jacqui Rock was appointed Chief Commercial Officer of NHSTT. I continued to play a leading role on all commercial work in mass testing. In this role I was supported by Pamela Doyle and Tim Byford, both of whom were Deputy Directors; Pamela continued to focus on increasing commercial laboratory capacity in preparation for the Winter and Tim remained the commercial lead in testing operations before transferring into the Quarantine Managed Service ("QMS"). Whilst I led on commercial procurement work, Jacqui Rock focused on establishing a more permanent organisational structure including the recruitment of replacement resources for CTT along with while also filling roles in her new organisational structure.

d. In January 2021 I returned to the CTT in the CO, however, I continued in an advisory capacity to NHSTT because of my knowledge and experience of the programme on an as needed basis. This continued until March 2021 at which point my advisory support was no longer required.

C. MY APPOINTMENT

10. Prior to the pandemic, my skills were as follows:

a. Procurement in both the private and public sectors. As a Civil Servant, I had worked in collaboration with government departments on FCDO's (formerly FCO) Project Atlas ERP implementation and the DWP HTP (Health Transformation Programme). My experience as a procurement and supply chain specialist included approximately 15 years as a consultant working across a wide range of sectors, including public and private healthcare. Other sectors in which I had worked included transport, construction, infrastructure, manufacturing, hospitality, retail, and public-private joint ventures (for example, adult and child social care).

b. I had no experience of procurement during civil emergencies.

c. I had no direct experience of coordinating the design and manufacture of specialist equipment, however, my experience of procurement in public and private healthcare often involved the procurement of specialist medical equipment, medications, supplies, consumables and services such as Cancer diagnostic endoscopy services in addition to laboratory supplies across NHS pathology laboratory networks. However, my academic background was scientific.

d. I had 20 years' experience in streamlining approvals and procurement processes to deliver improved qualitative outcomes and value for money.

e. I had no experience in scaling up domestic engineering and manufacturing capacity, however, at the beginning of my career I worked with international suppliers on scaling up in the context of food manufacturing.

f. I had 20 years' experience and skills in supply chain management.

11. The circumstances of my appointment to the role of Commercial Lead for NHSTT is as follows:

a. On Wednesday 18 March 2020 the Parliamentary Under-Secretary of State (Minister for Technology, Innovation and Life Sciences), Lord James Bethell, from the DHSC contacted the Chancellor of the Duchy of Lancaster and Secretary of State in the Cabinet Office ("CDL"), Michael Gove, for support to help in tackling the scale of the public health crisis posed by Covid-19. Michael Gove requested support from the GCF led by Government Chief Commercial Officer Sir Gareth Rhys Williams. It was in response to this request that CTT commercial specialists including me were deployed across various aspects of the requirement, initially on PPE, testing, ventilators and, later, vaccines.

b. My initial involvement came on 18 March 2020 when I was approached by Janette Gibbs, my then line manager, and told that I needed to attend a meeting in DHSC with Lord Bethell to discuss what was required to set up C-19 Testing capability. I refer to [BJA/2 - INQ000535741] in which Charles Stevenson of CO indicated at 10.13 that I would attend a meeting at 11.00, to which I replied at 10.30 stating 'I'll be there'. Matters moved quickly. I understood that I was asked to attend the meeting because of my commercial experience.

c. The meeting in DHSC was attended by Lord Bethell, Professor Sir John Bell, Regius Professor of Medicine at Oxford University specialist in Immunology & Genetics, and several civil servants from the Office for Life Sciences ("OLS") [BJA/3 - INQ000535738]. During the meeting, Professor Sir John Bell explained that we had at present little testing capacity (2,000 to 3,000 tests a day) which had to be increased in a matter of days. I returned to the CO and explained to CTT that I was being immediately deployed to DHSC.

d. As can be seen from document [BJA/3 - INQ000535738], on 18 March 2020 at 14.06, a follow up email was sent to all those involved in the workstreams to increase the testing capacity to 100,000; I was listed as lead for 'Commercial'. Initially, I had no terms of appointment: my role was not formalised, and the NTP, latterly NHSTT did not pay for me, until approximately three months later (from July 2020 onwards). Instead, others and I worked on the understanding that our aim was to scale up testing capacity. We all understood what our roles were and operated within a flexible structure. While it was a highly pressurised and fast paced

environment, there was a lot of camaraderie and collaboration during the 'start-up' period.

e. One of the first things I did was build my team. At 9.40 on 18 March 2020 an email was sent by Charles Stevenson on behalf of Gareth Rhys Williams of CO, to various individuals in the following terms:

> *"Emily / Steve / Jin (on Gareth's behalf), Lord Bethel (who has been brought in by Lord Agnew) has 2 things going on of interest:*
>
> *1. Lord B has a meeting at 12pm with a German cmopany [sic] offering quite substantial amounts of testing equipment. If the meeting goes well we need an aeroplane on hand to go and collect. Jin is already helping.*
>
> *2. Lord Bethel is worried about other testing equipment procurement in general and has asked for 25 commercial experts to be deployed to work on it. We can get hold of those people v quickly (we have a list of resource) - but they need to know who to dock into at NHS/DHSC. Suzanne or Chris' equivalents. Who is it?"* [BJA/4 - INQ000535739.]

At 2.19pm on 18 March 2020 (after the meeting in DHSC) I responded to the issue of the number of people I would need in my team, stating:

> *"Hi Kristen,*
>
> *We definitely don't need 25. I think in the first instance me and one other from my team will be enough. The bigger the team the less efficient we will be. I've just got to handover my current work to colleagues then I will be back over to DH. In the meantime if you can send me any information that you have that would be really helpful. Best regards, Bev"* [BJA/5 - INQ000535737].

I had only had one introductory meeting at this point and wanted to be clear on what was needed so I could ensure the right size team with the skills required before multiple resources were deployed. My position on this changed very quickly and I requested more people from CTT the next day. I spoke to my line manager to provide a steer

on the skill sets needed as I knew we would be working at pace under significant pressure often with limited direction dealing with significant complexity and uncertainty.

12. In terms of the elements of NHSTT that came within my remit:

    a. NHSTT was established on 28 May 2020 after it had been decided earlier in May that a dedicated testing function was required. Prior to that my role was as stated above: I led the Commercial team as part of the joint effort to increase daily testing capacity to 100,000, which we achieved.

    b. Prior to NHSTT, between March and May 2020, was the NTP. The structure of NTP is explained below at [add reference]. By way of summary, I resourced the team around the quickly established workstreams. Pamela Doyle, Tim Byford and I formed the Commercial Leadership team. We directed commercial work according to priorities but also actively led on negotiations ourselves. We initially engaged with Edward James (Commercial Deputy Director, DHSC) but he soon transferred away from Testing to focus on PPE. Lucy Mason (Commercial Deputy Director, DHSC) replaced him as our key commercial stakeholder in DHSC and became a key member of our Commercial leadership team. Whilst Lucy Mason was involved in some of the commercial delivery work (e.g. enzyme-linked immunosorbent assay ("ELISA") tests), she played a critical role in advising us on process and governance requirements and led in establishing streamlined governance processes. During this period our responsibilities were to secure suppliers and deliver all contracts required to increase daily Covid-19 PCR testing capacity to 100,000 and secure a supply of antibody LFTs. Towards the end of April our activity expanded into identifying alternative Covid-19 testing solutions (e.g. loop-mediated isothermal amplification ("LAMP"), LamPORE, Point of Care ("PoC") testing technologies such as DNA Nudge and Samba II) and expansion of daily testing capacity beyond 100,000.

    c. Following the establishment of NHSTT, the commercial team continued to be responsible for securing all contracts to deliver Covid-19 Testing but this expanded into increased volumes to deliver the capacity targets which had been set and the procurement of alternative testing technologies including antigen LFTs while also looking to stabilise supply for the longer term, improve efficiency and reduce costs. The team we established did not get

involved in procuring contracts for Trace operations. That team was led by Christopher Barlow. From mid-August 2020 onwards we significantly expanded the Team under Jacqui Rock's direction. She established an organisation structure and recruited longer term commercial resources. Those of us deployed from March 2020 started to conclude critical commercial arrangements and focus on induction and handover of the commercial work to the onboarding resources so we could start to transition back to our substantive roles.

d. When Dido Harding was appointed in May 2020 to head NHSTT, she focused her efforts on the tracing element. The commercial team we had established was left to continue with commercial procurement work around the testing element.

e. My colleagues and I were responsible for the commercial steps for products and services relating to testing which had to be procured. This covered:

   i. the procurement of PCR tests, both in relation to equipment (e.g. PCR machines), consumables (e.g. reagents, swabs, tubes etc) and logistics (test centres, labour, transportation, and laboratory services delivering PCR and ELISA); and

   ii. other testing technologies and ancillary services (e.g. LFTs), and

   iii. endpoint PCR ("ePCR").

f. When NHSTT was established, it had no budget or delegated authority. All contracts still had to be signed by DHSC personnel for this reason. Therefore, whilst I and the team often led the negotiations, drafted the contracts, agreed the terms, drafted the business cases, obtained necessary approvals and wrote the contract recommendation reports, no one in the commercial team signed contracts as we were not DHSC commercial employees so had no delegated authority to sign contracts. When Jacqui Rock was appointed Chief Commercial Officer of NHSTT in August 2020, she had delegated authority to sign contracts.

13. As Commercial Lead for NHSTT, I was therefore expected to undertake the following work:

a. Establish and set up the commercial team and allocate suitable resources to support the workstreams in the NTP. While CTT colleagues formed the

largest component of the team it included those from OGDs and contractors as noted at para [insert reference]. I would assess candidates for suitability supported by Pamela Doyle and Tim Byford. Some were referred by others. When onboarding new contractors, we had to sift CVs and interview contractors with the support of other team members. It was a tough environment to work in, so it was important to select individuals not just based on skills and expertise but their ability to cope with the pressures that came with the role.

b. Deliver all contracts required to deliver end to end PCR testing e.g. from sample collection through to test processing.

c. Contracts for antibody testing (LFTs and ELISA).

d. New testing technology.

e. Enable the workstreams to deliver their objectives through identifying, securing and procuring the necessary supplies, [BJA/6 - INQ000535734], whether from existing or new suppliers. As can be seen from the email sent by Kristen McLeod of OLS on 18 March 2020 at 9.54pm, documents [BJA/7 - INQ000535743] and [BJA/8 - INQ000535742], I was also asked to get *"ball park costs for each stream? (Am afraid we have nothing now)."*

f. Liaise and communicate with No. 10. This required me to join a No. 10 conference call each day with colleagues from the OLS. The first of these was on the evening of 18 March 2020 at 7pm. The daily meeting continued every evening until 23 March 2020 and then switched to twice daily with an additional catch up at 7.40am from 24 March until 31 March 2020. The meetings then reduced to once a day in the evening from 1 April until 17 April 2020. This meeting was routinely attended by myself, Kathy Hall (leading NTP Policy), Samantha Roberts (Supply Chain), Kirsten McLeod (Director of the OLS and SRO for Workstream 2 (third party testing labs)), William Warr (No. 10 SpAd for Health), and Professor Sir John Bell. The meetings were also attended by various Industry representatives from pharmaceutical companies (e.g. AstraZeneca and GSK), supplies (e.g. Randox and Thermofisher), and logistics (e.g. Amazon). Whilst it was not always the same representatives, I exhibit a document which references an invite list [BJA/9 - INQ000535753] and the key actions from the first meeting I attended on 18 March 2020 [BJA/10 - INQ000477236].

g. Engage with Ministers as required (mainly in Cabinet Office and DHSC). This would include daily or weekly sitreps, industry engagement sessions, meetings with suppliers, scientists and other stakeholders. Engagement was also in writing through advice notes and ministerial submissions requiring approvals/decisions ([BJA/11 - INQ000129066] – example of actions from early Testing meeting with Secretary of State)

h. I also worked closely with Communications to support in the drafting of Ministerial announcements, press releases and responding to Media enquiries of which there were many.

i. Lead engagement with Cabinet Office Controls in obtaining approvals of business cases. I exhibit [BJA/12 - INQ000561748] as an example approval for a Serology business case. I built strong relationships with colleagues in Cabinet Office Controls. We would have at least weekly meetings, and I would ensure they were kept updated.

j. Engage with Government Legal Department (GLD) to review procurement decisions with the aim of mitigating risk. We built strong relationships with GLD and they became embedded in our team. We also engaged with Government Property Lawyers when securing sites for Test centres e.g. airports, local authorities, retail outlets etc.).

14. With regard to (a) and (b) above, while not formalised, in practice I essentially assumed the role of Commercial Director. As overarching commercial team lead, I initially led and coordinated activity across pillars. I would pick up contracts where needed, to comply with the prioritisation and urgency which had been decided by those making those decisions, and I supported and advised my colleagues in their negotiations. Later I took on the leadership of workstream 1 (NHS Testing and New Testing Technology) as we looked to diversify from being solely reliant on PCR. Upon the departure of Samantha Roberts, in circa early to mid-June. I took over the SRO role for the work Deloitte were delivering to create a solution that accurately mapped supplies and testing capacity in real time across the NHS laboratory. This work was resourced by a small team of four to five individuals from Deloitte led by Ben Davies. I was not responsible for Deloitte's wider deployment across NTP/NHSTT. I continued to have oversight across all workstreams and pillars. I was a core member of the Innovation and Partnership Community led by James O'Shaughnessy and chaired by Lord Bethell, the purpose of which was to identify innovations and solutions that could build on and improve our testing capability (I

refer to the following minutes and actions: BJA/13 - INQ000535811, BJA/14 - INQ000535801, BJA/15 - INQ000535820). I also worked closely with the Diagnostics Innovation Team, in particular Piers Ricketts and Zain Sood (I refer to BJA/16 - INQ000535802 as an example weekly update on the scope of activity).

15. I brought in several other CTT commercial specialists who were deployed to DHSC's NTP in the days following 18 March. Over the weekend of 21 and 22 March 2020, I deployed the following individuals to lead on each work stream (of which there were three at that point) while retaining overarching commercial accountability and oversight across all workstreams:

    a. For NHS C-19 lab-based testing, I brought in Phil Newman. After a few weeks I redeployed Phil into more of a contract management/strategic supplier relationship management role given the magnitude of some of the arrangements that were being put in place and I took over as lead of this workstream (in addition to my existing overarching role).

    b. For Third Party C-19 lab-based testing, I brought in Tim Byford.

    c. For Rapid C-19 antibody testing of key workers and surveillance testing, I brought in Pam Doyle.

16. By the weekend of 21 to 22 March 2020 CTT had deployed an initial team into the NTP consisting of me, Tim Byford, Pam Doyle, Phil Newman, Anna Slominska and Alicia Caley. Over the following days and weeks Bryony Gale, Jessie Crabtree, Audrey Wignolle and Christian Destombes joined this team for varying periods. Bryony Gale was loaned in from the DIT but had previously worked in CTT and during deployment in NTP/NHSTT she transferred back to CTT. The last team member left Testing (by then part of UKHSA) in January 2022. Tim Byford transferred to work on the Quarantine Managed Service – QMS and did not return to CTT.

17. As a result, a commercial team was set up that consisted of between 25 to 30 individuals at any one time, delivering procurements for NTP/NHSTT from 18 March 2020 through to the early August 2020. The team was made up of CTT colleagues (as referenced above), a few external contractors, GCF colleagues from OGDs on loan, PHE and DHSC commercial colleagues. All team members that delivered procurements in support of providing testing capability between March 2020 and August 2020 were critical as were many of the Consultants and Contractors onboarded from August 2020 onwards. However, in terms of key personnel

providing leadership and direction on procurement decisions, that would include Tim Byford, Pam Doyle, Lucy Mason and myself.

18. The individuals in this commercial team were not deployed for the full duration of this period hence the team being made up of between 25 to 30 individuals at any one time (whilst the total amount of staff over the period was 37). For context, for the first 6 months this core number of resources delivered the commercial work of a team that soon become circa. 200 resources by the end of 2020 under Jacqui Rock's direction. This is important context for understanding the scale of work that had to be delivered by so few. The team worked across all workstreams/Pillars and individuals would be deployed to deliver contracts according to priority, so they would work across workstreams/pillars as needed. While additional delivery support was provided by third parties (e.g. Deloitte across the Testing Programme) and NHS Supply Chain colleagues (e.g. on supplies to the NHS), all commercial negotiations that led to contracts across all workstreams/pillars, were led and delivered by this Commercial team during this period.

19. I, together with other CTT individuals who had also been deployed, initially set up the commercial resource structure to support the three workstreams ("Pillars"). I cannot recall the exact date when these workstreams were established but I estimate it being around 20 March as references referring to the workstreams 1 to 3 appear in emails from 21 March onwards and on 17 March a document was drafted with the title 'Coronavirus Mass Testing Strategy' which summarised four key priority areas that became the first four pillars [BJA/17 - INQ000055915]. The 5-pillar structure was in place by 4 April (Coronavirus (COVID-19) - Scaling up our testing programmes). They were as follows:

    a. Pillar 1 (initially referred to as workstream 1 or "WS1") was NHS C-19 lab-based testing and was to leverage the existing NHS laboratory testing network. This involved procurement of ordinarily everyday medical items such as swabs and reagents in the early stages of the crisis with global shortages and unprecedented global competition but also capex equipment such as PCR machines. This area settled within the early months of the pandemic and the volumes procured plateauing at a capacity that was agreed with NHS leadership. Very quickly (within days) it was clear that Pillar 2 expansion was how the demand for capacity would be fulfilled and this was represented by the significant volumes procured through this pillar across multiple categories of spend. It's worth noting that while we had

distinct pillars we would not operate in silos; similar requirements across pillars were consolidated and leveraged in their totality e.g. reagents, swabs, PCR equipment etc. For example, when we agreed to purchase RNA extraction and Covid-19 PCR testing reagents from Thermofisher we would secure volume to supply Pillars 1 and 2 and it would be negotiated as one contract that multiple parties would call off from.

b. Pillar 2 ("WS2") was Third Party C-19 lab-based testing. This was set up to utilise third parties to deliver C-19 testing with the aim of significantly increasing testing capacity to alleviate the strain on the NHS. This Pillar implemented a system which had never existed before, for the operational delivery of mass testing which embraced the collection of samples from the public (from drive-in test sites, mobile test units and walk-in urban sites), the identification or setting up of laboratories to execute the tests, the logistics to move samples and supplies (including testing at home) and the system to deliver the results. Within 6 weeks, by the end of April 2020, this had become an organisation of over 20,000 staff, which comprised suppliers, contractors, military and a handful of Civil Servants. The size of the organisation grew as daily testing capacity increased from May onwards. See document [BJA/18 - INQ000561740] which provides a workstream/pillar 2 commercial team overview dated 14 April. It includes a helpful visual on the logistics involved in end-to-end PCR testing, commercial team size, volumes required and categories of spend.

c. Pillar 3 ("WS3") - Rapid C-19 antibody testing of key workers – to secure supplies of suitable antibody tests which could be used daily by key workers to detect C-19 antibodies. The theory at the time was that the presence of antibodies indicated the individual had been exposed to C-19 and had therefore developed immunity. The assumption was that this would suggest such individuals posed less of an infection risk and therefore would be able to attend the workplace. Like Pillar 1, this entailed procurement in a global market, with emerging technology, highly limited supply (principally from China) and uncertainty of effectiveness in managing the spread of C-19.

d. Pillar 4 was Surveillance Testing and required some separate commercial support, being delivered through Pillar 3 in collaboration with Ipsos Mori (IM); a procurement to secure the testing facility, working with the IM team to agree what commodities were required for the requirement and

subsequent oversight of placing those procurements. I personally was not actively involved in this pillar as Pamela Doyle led commercial activity for this pillar and there had been no need to escalate any issues or increase resources, the volume of work being less than across some of the other pillars. Pamela had to work to resolve some of the technical issues with supply partners relating to handling, storage conditions and collection of tests being distributed across a large network of the homes of the general public.

e. Pillar 5 was Diagnostics National Effort and it was established by Lord Bethell by 4 April 2020. The remit of my engagement in this pillar was to attend industry engagement sessions where we would flag the priority areas of supply to generate offers from the Life Science Industry. I would also engage directly with suppliers referred or identified through this pillar as well as through our own research and contacts. See document which includes the submission for Pillar 5 providing detail of approach to engaging industry including the process for triaging offers, [BJA/19 - INQ000535762].

20. When I left NHSTT in December 2020 and went back to CO, I stayed part-time for three months. This was by agreement with Jacqui Rock that I would provide advisory support as needed [see documents which include the Programme Engagement Letter (PEL) and my handover document BJA/20 - INQ000535875, BJA/21 - INQ000535891, BJA/22 - INQ000535888]. This was because I had been in Covid-19 Testing from the very beginning, had been involved in two judicial reviews (Project Moonshot and Abingdon Health) and therefore had a 'corporate memory'. Very few people had this level of continuity of knowledge covering this period due to the high turnover of people. I therefore remained in the role of 'advisory support', but it was very arm's length, was ad hoc and I filled the gaps as required. That role included continued knowledge transfer to those new to NHSTT.

D. NHSTT

21. We started with one type of test, PCR. As we learnt more about Covid-19 and how it worked, infection rates, transmissibility and everything, it started changing our approach to what tests we needed. These decisions and commitments were made at a point when we did not have a vaccine. It's also important to note that during most of the period of my tenure in NHSTT, the UK was under lockdown. In addition to the human cost and strain on the health service that C-19 caused, No. 10 were cognisant of the significant cost to the economy for every day the UK was in

lockdown. This led to the need for testing to provide a means to support the objective to allow a return to more normal activity and ultimately the ability to lift lockdown, rather than solely being a diagnostic solution to identify those who were infected.

22. As to NHSTT within government, it is important to set out how the Testing Team was created and evolved, because that explains how I worked with various government departments. I have explained above that I brought in other CTT colleagues who like me had been in the CTT in CO and who were then therefore immediately deployed from CO to DHSC. The whole of CO's CTT was at that time around 50 individuals, all of us working as internal consultants. We worked on any high-risk project across all of Government. On and following 18 March 2020 we were pulled from every piece of work we were working on. I had been working on projects for FCDO/DWP. We were all pulled off existing programmes and put on Covid-19, whether it was ventilators, PPE, or testing. So, my working with CO was that I had been in CO and the CTT colleagues I deployed to the Testing Team were also in CO. I remained employed by CO (as did the other CTT colleagues), even though I was working in/deployed to DHSC. CO's role was therefore to provide these resources (i.e. personnel) which were needed to set up, progress and sort out procurement for Testing.

23. However, instead of reporting to CO, I was now reporting to DHSC ministers and on a day-to-day basis all decisions as to testing were made within DHSC. In terms of direction, I received that from senior officials engaged in the NTP in DHSC (including those seconded from other departments). I dealt predominantly with Testing pillar SRO's, DHSC Second Permanent Secretary, David Williams, Supplies Director, Samantha Roberts, Policy Lead, Kathy Hall and Minister Lord Bethell in addition to SpAds in No. 10. Once NHSTT was established I continued to engage with appointed SROs, but my engagement expanded to include Dido Harding as head of Test & Trace and her leadership team.

24. I did however also check in regularly with CO: I would give daily updates to Gareth Rhys Williams who was the Government CCO of GCF and to Lord Agnew who was Minister of State for Efficiency and Transformation jointly for CO and HMT. These daily updates started in April through to July when they reduced in frequency (twice-weekly). See documents [BJA/23 - INQ000535767] and [BJA/24 - INQ000535779], the latter of which covers the significant milestone of reaching a daily testing capacity of 100,000, see [BJA/25 - INQ000561745] and [BJA/26 - INQ000561746]. Note that rather than email an update to Gareth Rhys Williams, I used to update a live shared

document daily but it was essentially the same update as that provided to Lord Agnew. There were occasions when Gareth Rhys Williams and Lord Agnew raised concerns about the spending decisions that were being made by NHSTT and the short notice provided to Cabinet Office Controls in requesting their approval of business cases. Exhibits [BJA/27 - INQ000477938], [BJA/28 - INQ000198134] and [BJA/29 - INQ000480131] detail two such examples; Lighthouse Laboratories Expansion and the case for purchasing 223.5 million lateral flow tests. I drafted the Lighthouse Laboratories Expansion business case and the process had been protracted and frustrating due to what I saw as indecisiveness around the target daily capacity and how to approach the distribution of that capacity. While this case initially settled on 500k, soon after approval we had to revisit to hit a revised target of 800k [see exhibits BJA/30 - INQ000563082, BJA/31 - INQ000563399 and BJA/32 - INQ000563081 referencing the drafting of a submission to expand capacity to 800k tests per day dated July 2020.. Drafting in itself with inputs from multiple sources was inefficient and with no capability to amend in real time on a shared platform, version control was onerous. Obtaining approval within DHSC had also been protracted and challenging so by the time it was ready to send to CO and HMT, we had lost so much time we were significantly at risk of not being able to mobilise in time to deliver the testing capacity required for winter.

25. While I was not copied on all emails referenced in Exhibit BJA/28 - INQ000198134 / SRI00000154, I believe one particular exchange alludes to this when Kate Josephs, Director General, Cabinet Office states in an email to Simon Ridley with multiple individuals on copy that *'Raghuv has been very honest to my team that T&T deserves much of the blame for this debacle.'* Raghuv was Chief of Staff to Baroness Dido Harding. I responded in full to the questions raised by Gareth Rhys Williams, Lord Agnew and Alex Chisholm [refer to exhibits BJA/33 - INQ000563079 and BJA/34 - INQ000563398 – Lab Capacity Submission, BJA/35 - INQ000563074 and BJA/36 - INQ000563397 - the business justification that went to CO Ministers and Controls, BJA/37 - INQ000563076 and BJA/38 - INQ000535833 – draft response addressing Cabinet Office's questions]. The email correspondence in BJA/38 - INQ000535833 sets out the query from GRW as to whether there was a reason why there should not be a competitive procedure, and DHSC's (TT's) response.

26. The second example referenced was similar in regards to raising an urgent request for approval from Cabinet Office and HMT. While we had already planned to buy circa 180m lateral flow tests following our initial purchase, the instruction to buy as many lateral flow tests as available by the end of the day was provided by No. 10 on

Friday 2nd October 2020 [BJA/39 - INQ000561757]; James Phillips sent the original email expressing his concerns in delaying buying decisions with Dominic Cummings replying on the email thread *'Agree – buy buy buy. I cannot begin to describe PM's reaction if we miss the chance to buy 200m of these things cos we're thinking about what to do with them, waiting for CST to sign a letter etc. Id like the deal done by COP today and planes in the air ASAP to collect, using military planes if necessary.'* Further relevant exhibits are referenced in paragraph 122. As with the first example, Gareth Rhys Williams raised some questions which I answered as part of the submission requesting approval following a direct conversation [see exhibit BJA/40 - INQ000535870]. As mentioned later in this statement, we did not conclude the deal by the end of the day but concluded negotiations that were already in progress over that weekend which saved hundreds of millions of public money.

27. Ongoing, the tension between DHSC/NHSTT and the Cabinet Office were resolved in the main by my team and I having a closer relationship with Cabinet Office Controls, sharing a pipeline of likely business cases with as much notice as possible. We would have constructive discussions on what they needed to see as we learned from previous cases which helped in pre-empting likely questions which helped reduce delays in approval times. However, there would still be occasions where decisions were made at short notice and we would have to expedite preparing for approvals with little warning. From my perspective, while these challenges often entailed additional work and increased pressure for me and my team in evidencing value for money and providing justification for decisions being made, I welcomed the rigour as it provided an opportunity to amplify concerns we had often already raised with stakeholders in what was initially the NTP within DHSC and latterly NHSTT. I have referenced several examples in this statement demonstrating the pressure Commercial were under internally and externally to deliver at pace and the level of resilience we had to exhibit to influence efforts to ensure funds were spent responsibly (e.g. paragraphs 77, 87 and 137, 163, 171 and exhibit BJA/41 - INQ000563401 which is an example of the common type of exchanges with suppliers) .

28. Following 18 March, I (along with others who had been deployed from CO to DHSC), initially thought we would only be with DHSC for a short time. I therefore retained and used my CO laptop.

29. However, once we approached the three-month period of deployment in DHSC at no cost, it was Gareth Rhys Williams and Janette Gibbs' (interim CTT Director)

preference to terminate CTT's deployment in NHSTT. The main reason was driven by:

a. concern for wellbeing due to the nature of the work, high pressure environment and long working hours we had been sustaining for months and;

b. the recognition that NHSTT needed to establish an organisational structure to include an appropriately resourced Commercial team that would be able to deliver in the medium to long term. The purpose of CTT is to deliver on time limited complex and challenging projects across Government and was not intended to fill longer term resource gaps.

30. It is my understanding that Dido Harding challenged this position reasoning that there were no suitable resources to replace CTT personnel and it would be detrimental to NHSTT to extract us at this point. Gareth Rhys Williams and Janette Gibbs agreed to extend the deployment for an additional three months under the caveat that we would revert to our regular process of charging for our time under a formal agreement of scope of work and that NHSTT would work to establish a Commercial function which would look to recruit resources to replace the CTT led Commercial team. All personnel were offered the opportunity to exit at this point if they wished to, but core CTT personnel agreed to extend their deployment. It did not change our employment status.

31. As noted earlier in this statement, the Commercial team did not have delegated authority or its own budget, and all testing contracts were with DHSC. In May 2020 it was decided that the NTP needed to have more autonomy from DHSC. This is when Dido Harding was brought in to lead and develop the NTP into an organisation that would broaden its remit beyond Covid-19 diagnostic testing capacity. Initially it was going to be called NHS Test, Track and Trace but then it was changed to NHS Test & Trace as the word Track had negative connotations with the idea of 'surveillance.' While NHSTT would operate like it was a separate entity to DHSC, it did not have legal status as such so all contracts continued to be with DHSC. It is my assumption that this was because there was still a view that the organisation would be temporary which is why anyone joining was contracted on three-month terms which is one of the reasons it was challenging to recruit and retain resources. I refer to document [BJA/42 - INQ000535814] which details the handover of the NTP infrastructure to NHSTT under Dido Harding's leadership.

32. Part of my role from the outset was to negotiate testing contracts. I negotiated them to the point of signing, but did not sign them because I was always employed by CO, not DHSC. Early in our deployment, DHSC had requested that CTT personnel including myself should be given delegated authority to sign contracts [BJA/43 - INQ000535758]. From my recollection, Gareth Rhys Williams and Janette Gibbs declined this request explaining it was not good governance for CO staff to sign contracts on behalf of another Government department. Once it was confirmed I would remain in NHSTT for at least three more months I decided to obtain a DHSC issued laptop as it was becoming increasingly difficult not having access to their systems and infrastructure e.g. MS Teams, templates, shared sites etc. This is why from mid-July onwards, I switched to a DHSC laptop.

33. My dealings with the MOD was limited to their involvement for logistics in picking up PCR testing machines from universities. In the early days we needed PCR testing machines as this was laboratory-based testing and we used MOD for logistics when we did not have any other options. MOD would be used when there was an emergency and it was critical; I recall that they were used on several occasions. They would collect and deliver the machines. DHSC Headquarters (which was the base for Testing) had military people on site from the very earliest days, as they were good at managing logistics. As I have set out above, I brought in Tim Byford and Pamela Boyle to lead workstreams/pillars. Most MOD activity related to Pillar 2 – third party testing operations led by Tim so while I had awareness of their engagement, he was closer to the detail.

34. The NHS had some capacity for PCR testing as did PHE, but whole testing capacity was initially circa. only 3000 per day. So, one of the things we did in late March was to borrow machines from universities and other research institutions because they do PCR testing all the time and we were in lockdown which meant students and staff were not in the Universities, so the equipment was not in use. We borrowed PCR machines from a range of Universities. The decision to do this was a collective decision (we were always actively discussing solutions to problems, and this was prompted by the lack of availability of machines to purchase). The decision was ultimately approved by Minister Lord Bethell. See document [BJA/44 - INQ000535815] for the plan and process for returning/replacing borrowed equipment including volume of items.

35. The FCDO (at that point it was the FCO) were particularly helpful on the antibody LFT workstream / Pillar, given that most of it came from China. The FCO had a

'Covid Cell' based in Beijing. I occasionally spoke to individuals in the Cell as they helped me with sourcing swabs and other consumables for the NHS and third-party testing laboratories (lighthouse labs) Pillars 1 and 2 respectively. However, Anna Slominska and Pamela Doyle had most interaction with them as they were actively leading the negotiations on antibody LFTs. FCO did not contract on behalf of Testing, but they did carry out due diligence on supplier companies e.g. checking they were real, providing translation, checking credentials and confirming that products were at the airport and were despatched. That was all within the operation of the China Covid Cell. It was comprised of employees from FCO and was made up of individuals working at the British Embassy in China (personnel based at post).

36. The only other engagement that I had with the FCDO (FCO had recently merged with DFID) was in December 2020. The then-foreign secretary, Dominic Raab, chaired the Project DEFEND Board set up to test supply chain resilience across all Covid-19 capability. I know little about when it was created except that it consisted of a series of three small ministerial group forums, one of which I attended on 2 December. I first had sight of its existence on 30 November, and I was confirmed as attending on the afternoon of 1st December when Jacqui Rock asked me to accompany her which I agreed to. Unfortunately, a request for representation from NHSTT had been received a couple of weeks prior Jacqui being made aware and asked to participate which involved providing papers to be shared with the Foreign Secretary in advance of the meeting. The following email threads and documents set out how little time we had to prepare for this meeting – [BJA/45 - INQ000535880]; email thread on late request to support Project DEFEND meeting which includes the agenda, [BJA/46 - INQ000535881]; email thread relating to prep for DEFEND meeting, [BJA/47 - INQ000535882]; prep for DEFEND meeting - details Foreign Secretary's approach and preferences, [BJA/48 - INQ000535885]; diary invite for pre-brief of Project DEFEND meeting with Lord Bethell when I was first informed of the level of detail expected (circa. 15 mins before the meeting).

37. It was decided that Mark Hewlett should also attend as Head of Testing Operations (he had recently replaced Alex Cooper). We had limited insight to the scope and terms of reference of the Board, the format or expectations on our part outside of being able to explain the robustness of our supply chain in terms of security of supply. The morning of the meeting Jacqui, Mark and I had a preparatory call with Minister Lord Bethell and Jonathan Marron, DHSC Director General, Primary Care and Prevention. Minister Lord Bethell provided more insight to what the Foreign Secretary would expect of us indicating that 'his preference was to delve into detail.'

Minister Lord Bethell appreciated that we had had minimal time to prepare and said we should offer to follow up with detail if unable to confirm during the Board. The format of the meeting involved questions about stocks within our supply chain to a level of detail that was unexpected. For example, we purchased test cartridges for our DNA Nudge and Samba II point of care PCR testing solutions; the Foreign Secretary wanted to know all the components of the cartridges and the country of origin, supplies of stock, volume held in the UK and how much supply this equated to for each of these components. He required a similar amount of detail across all testing technologies that were in use. Given the range of coverage and level of detail being asked, I was best placed to respond to the questions and did my best to do so for the best part of an hour. While I could not answer all the questions, I was able to provide sufficient assurance to the Foreign Secretary – see documents [BJA/49 - INQ000535883], [BJA/50 - INQ000535886] and [BJA/51 - INQ000535884]. There were several other Ministers in attendance from across multiple Government Departments.

38. I did not personally engage at all with DIT. There were some DIT staff who were seconded to Testing and one of my key colleagues Bryony Gale was from DIT. However, DIT did receive offers from UK Businesses for items that would support the Covid effort and DIT would channel relevant offers to Testing. Sometimes these offers were channelled to me and sometimes to members of my team.

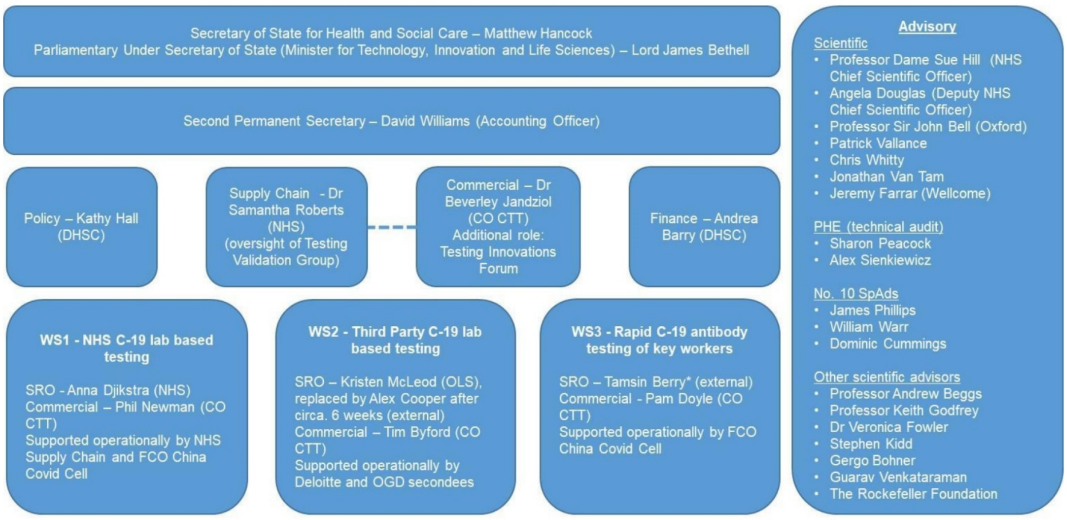
39. As to my dealings with BEIS, OLS was a joint unit across DHSC and BEIS. It is now a joint unit between DHSC and DSIT (Department for Science, Innovation & Technology). During my initial deployment into DHSC to support setting up the NTP, most of the individuals involved in setting up the workstreams to increase testing capacity were from OLS and were the first to make contact with potential suppliers and secure supplies before I became engaged; see documents [BJA/52 - INQ000535736], [BJA/53 - INQ000473907], in which Merewyn Loder sent an email on 18 March 2020 saying "*I will be co-ordinating the first workstream – on all the test, consumables etc..".* and the email sent on 18 March 2020 at 5.03, document [BJA/54 - INQ000535749], in which Kristen McLeod from OLS requested approval from David Williams, then Second Permanent Secretary for DHSC for finance approval to purchase £64 million of test kits from ThermoFisher Supplies ("TFS"); also document [BJA/55 - INQ000535732].

40. I did not have any engagement or dealings with UK Visas and Immigration, however, I did have some engagement with Home Office Border Controls in relation to helping

with Policy development and feasibility of Airport Testing. In an email exchange on the topic I summarised my engagement with Border Controls in June 2020; *"We would love to be connected to Heathrow on this. Piers team and myself have done a lot of scoping of this already and have some pretty detailed proposals and we have also consulted with Border Controls in the Home Office. We believe the preferable option would be to test at the airport and there are a number of point of care solutions that could facilitate this. The next step would be for us to engage with Heathrow in conjunction with Border Controls and other interested parties like DfT to firm up the approach. I believe it's something HMG should lead on in piloting at least to prove the concept and ensure the right testing solution is deployed for this use case. Border Controls also mentioned that if we are to pilot testing at airports we should also consider a port (they suggested Portsmouth) and possibly the Eurostar as they said if these alternative borders are not seen to be offered the same consideration as airports then they will raise a challenge. Can we set up a meeting to discuss? I've copied Piers, Zain and Jessie as they are close to the detail on this as we've been working on this together..."* [BJA/56 - INQ000535813]. I also include the Airport Testing Paper we shared with Border Controls and other documents/interactions referring to our activity which I worked on with my colleague Jessie Crabtree and Zain Sood from OCC Strategy Consultants who worked in the Covid-19 Diagnostic Innovations Team [BJA/57 - INQ000535816, BJA/58 - INQ000535817, BJA/59 - INQ000535808, BJA/60 - INQ000535807, BJA/61 - INQ000535810, BJA/62 - INQ000535809, BJA/63 - INQ000563073].

41. I did have engagement with NHS England and NTP/NHSTT worked collaboratively with NHS England, as is shown on the chart below which I compiled in November 2023 as an aide memoire when I was requested to support the Cabinet Office Covid-19 Inquiry corporate statement to show how my role fitted in and around other departments or individuals. NHS England and NTP/NHSTT collaborated in trying to secure supplies e.g. NHS England Supply Relationship Managers would connect us to suppliers. Other personnel were deployed/seconded into NTP e.g. Samantha Roberts was in place when I arrived and had transferred from NHSE & I (NHS England and NHS Improvement were integrated in 2018). There were other individuals seconded to work in Testing e.g. Anna Dijkstra came from NHSE & I and Katie Barker came from NHS Supply Chain. I was not involved in their recruitment and do not have clarity of the terms of their employment but assumed they were seconded to DHSC to support the testing effort in a similar way to myself and other colleagues from across Government. Whether seconded into Testing or continuing

in their business-as-usual roles, NHS personnel I engaged with were collaborative and helpful in supporting our efforts to secure supplies.



42. I had no direct involvement with Supply Chain and Coordination Ltd ("SCCL").

43. I had no direct involvement with HSE.

44. As to my engagement with the Medicines and Healthcare products Regulatory Agency ("MHRA"), with the development of new tests whether new Covid-19 PCR tests or alternative testing technologies such as LFTs, MHRA approval was required. MHRA is the designating and competent authority in the UK whose role is to assess whether manufacturers and their medical devices meet the requirements set out in the Medical Devices Regulations 2002 (SI 2002 No 618, as amended) ("UK MDR 2002"). Relevant items associated with Covid-19 Testing would be those that are considered in vitro diagnostic medical devices, covering any medical device which is intended for in vitro testing (Part IV of the UK MDR 2002). Sometimes we bought products that had not yet been approved by MHRA due to the urgency of requirement. For example, we procured Hologic's C-19 test for use on their Panther PCR machines prior to receiving MHRA approval. We were confident with the technical validation of the product and included a clause in the contract which set a timeframe for Hologic to gain MHRA accreditation for the test. My personal engagement with MHRA was on an as needed basis, the nature of which was mostly around clarifications relating to MHRA process in considering approvals of products for supply. I mostly dealt with Graeme Tunbridge who was very helpful and supportive e.g. *"From an MHRA perspective we are clear that we can facilitate any supply of consumables without CE marks where they offer a suitable alternative to*

a regulated product so this should not be considered a barrier of any kind." [BJA/53 - INQ000473907]. Also on 18 March 2020 at 1.34 pm I sent an email to Graeme Tunbridge of MHRA in the following terms: *"Hello Graeme, I've just been asked to send you the form BEIS are using to call for suppliers who may be able to supply ventilators or parts. The view is we need a similar form to put out for the COVID-19 diagnostic testing requirement*." [BJA/64 - INQ000535740] and received a reply at 2.24, [BJA/65 - INQ000535748].

45. My only engagement with MHCLG was on about two or three occasions when I sat on a forum with representation from local authorities - it was a monthly forum to which I went on a very few occasions and gave an update on testing and answered any queries which the representatives had. I would update them on our goals for increasing daily testing capacity in preparation for winter and the types of alternative diagnostic tests we were exploring e.g. LFTs, endpoint PCR.

46. As to my engagement with Advanced Manufacturing Research Centres, I take this to mean entities such as McLaren. They worked on ventilators and in September 2020, it is my understanding that Gareth Rhys Williams asked them to get involved with Testing to look at increasing the automation and efficiency of Covid-19 Testing capability (e.g. LAMP and PCR). We had an advisor from McLaren, Mark Mathieson who was the main McLaren contact I dealt with. See [BJA/66 - INQ000535856]; email thread relating to onboarding of McLaren - 23/09/20. Note indication of £500k budget, [BJA/67 - INQ000535858 and BJA/68 - INQ000478822]; exchange between Gareth Rhys Williams and Dido Harding with notes from visits undertaken with McLaren.

47. I dealt with the Devolved Administrations by way of a "knowledge exchange". I would engage with counterparts through Lauren Rabaiotti, COVID 19 testing programme – Devolved Administrations lead Department for Business, Energy and Industrial Strategy / Department of Health and Social Care and Helena Peacock Senior Officer - Policy & Mass Testing Devolved Administrations National Testing Programme. I regularly sent updates and information to them to share with the DAs and they would schedule regular meetings.

48. As is set out on the chart above, I dealt with PHE on a regular basis, with personnel involved in the validation of tests and accreditation of testing laboratories e.g. Sharon Peacock and Alex Sienkiewicz. Nilesh Pattani who led the procurement team in PHE was a core member of our Commercial team and he led the work on tendering a new Microbiology framework.

49. In addition, I worked with lots of academics and science groups, from multiple academic institutions. Those I engaged with most frequently included Professor Sir John Bell, Regius Professor of Medicine at The University of Oxford (who was brought into the meeting on 18 March, I think by No. 10), Dame Professor Sue Hill and Professor Angela Douglas, Chief Scientific Officer, NHS England and Deputy Chief Scientific Officer, NHS England respectively. I also engaged with scientists at PHE and at PHE's laboratory facility at Porton Down where much of the testing validation work was carried out (as noted above). Testing validation work would be commissioned by the Testing Validation Group (in its various forms and iterations). This was a cross-functional group who would decide which solutions were worth pursuing or should be prioritised for validation. I engaged with a lot of scientists, more so than what would be usual for a Commercial person. My scientific background meant I could engage in conversation with scientists and understand from a technical perspective, which also enabled constructive challenge. We had limited resources, so we all used whatever skills we had to deliver what was needed even if outside the theoretical scope of our roles. For example, my role as part of the Innovations Partnership Community, proactivity in identifying new testing technologies and leading role in the direct LAMP pilots which represented a turning point in considering testing as an opportunity to reopen society rather than as purely diagnostic; *"Dear Bev, Many thanks for this update. This is looking very exciting and I look forward to more information as the study progresses. This could be a very important methodology and approach. Best wishes, Patrick"* - note from Patrick Vallance in response to interim pilot report from email thread [BJA/69 - INQ000535822] and additional exchange with Professor Sue Hill and Patrick Vallance, [BJA/70 - INQ000535826].

50. The key people who I worked with in relation to the procurement and distribution of key healthcare equipment and supplies were Samantha Roberts, Supplies Director and her wider team. The members of her team I most frequently engaged with were Andrea Barry - Finance, Anna Dijkstra - Testing Supply, Piers Ricketts – Diagnostics Innovations, Paul Chambers – Lab Capacity, Neill Moloney – Supply Operations Lead, Lindsey Hughes – Crowd Sourcing and Daniel Bamford – Validations. It is important to note that not all these individuals were in these roles for the duration of my deployment in NTP/NHSTT but engagement continued with these functional roles in their various iterations.

E. STRATEGY DURING THE PANDEMIC

51. By the words "LFTs and PCR testing equipment" I refer (as is required by the guidance in the Rule 9 dated 30 September 2024) to the equipment and logistics required for the end-to-end process, including sample collection kit (vial, swab, and relevant packaging), transportation to a laboratory, the laboratory testing itself, laboratory equipment necessary for processing PCRs, consumable reagents and ending with the return of the results.

52. On 18 March 2020 I received a document which appears to have been compiled on 17 March 2020, [BJA/17 - INQ000055915], headed "Coronavirus Mass Testing Strategy". This underpinned the Government's strategy and therefore my strategy for procuring antibody LFTs and PCR testing equipment and consumables, for example the need to include a range of scientific methods where fit for purpose.

53. At the onset of the pandemic we needed supplies as quickly as possible. Lead times were already long for equipment such as PCR machines where manufacturing existed. However, where possible we looked for opportunities to expand UK based manufacturing where they already had some capability e.g. Randox had an established PCR processing laboratory which is why we chose to expand their operation. This was also the motivation for onboarding the UK Biocentre as the first lighthouse lab. Also Hologic expanded their manufacturing capacity in the UK which served to our advantage in being able to secure their newly developed C19 PCR test for use on the Panther PCR system and we also worked with Novacyte to expand their PCR test manufacturing capacity through committing to increased volume of supply and later with Oxford Nanopore for LamPORE [BJA/71 - INQ000561738 and BJA/72 - INQ000561739 reference suppliers with UK manufacturing so we could look for opportunities for supply expansion]. A focus on delivering an uplift in manufacturing capacity in the UK came later circa. August 2020 when Frazer Bennett from PA Consulting transferred from working on Ventilators to working with our supply base on opportunities to grow manufacturing capacity. Chris Hall from Cabinet Office also worked on this and from September 2020, one of my CTT colleagues Rob Nixon accepted one of the Director roles in Jacqui Rock's new organisational structure and took on the leadership of the UK Manufacturing workstream.

54. My immediate strategy for the procurement of LFT and PCR testing equipment was to secure the supplies and partnerships required to deliver the diagnostic testing capacity required as referenced in [BJA/17 - INQ000055915] which expanded further

as published in the NTP strategy. We had to be agile in our approach as we were operating during a period of emerging information and insight from scientists and medics, peaks and troughs in infection rates, viral mutations, vaccine development and changing policy in relation to lockdown enforcement. My procurement strategy was being focused on delivering:

a. increased diagnostic capability and capacity;

b. diversification of solutions to improve resilience within the supply chain, reduce costs and capitalise on innovation;

c. increased access to diagnostic testing and reduction in sample to result times;

d. the provision of fit for purpose solutions for antibody detection; and

e. identify and secure testing solutions suitable for mass testing to reduce infection rates and support the reopening of society.

55. Initially the priority strategy was to increase diagnostic capability and capacity with the initial target which had been given to us by the Prime Minister of growing daily testing capacity from circa. 3000 to 100,000 by the end of April. This target incrementally increased from May 2020 onwards. Daily testing capacity refers to the ability to process the target number of tests during a 24-hour period. Having the capacity to do so does not necessarily equate to actual tests processed. The strategy to achieve this was to:

a. Maximise existing capacity in the NHS laboratory network. For example, by repurposing the use of the NHS Hologic Panther PCR systems for Covid-19 testing we were able to increase NHS capacity by 1 million per month.

b. Establish 'lighthouse labs' run by third parties to provide dedicated PCR testing hubs.

i. Partner with other third-party labs to provide resilience and surge capacity when needed e.g. to cope with the demands associated with spikes in infection rates.

ii. Build an infrastructure for the collection of test samples from the general public (testing centres). Boots helped set up the first test centres for swab collection.

iii. Logistics infrastructure for collection of samples to be delivered to test processing laboratories. Amazon was one of the first providers to deliver this service.

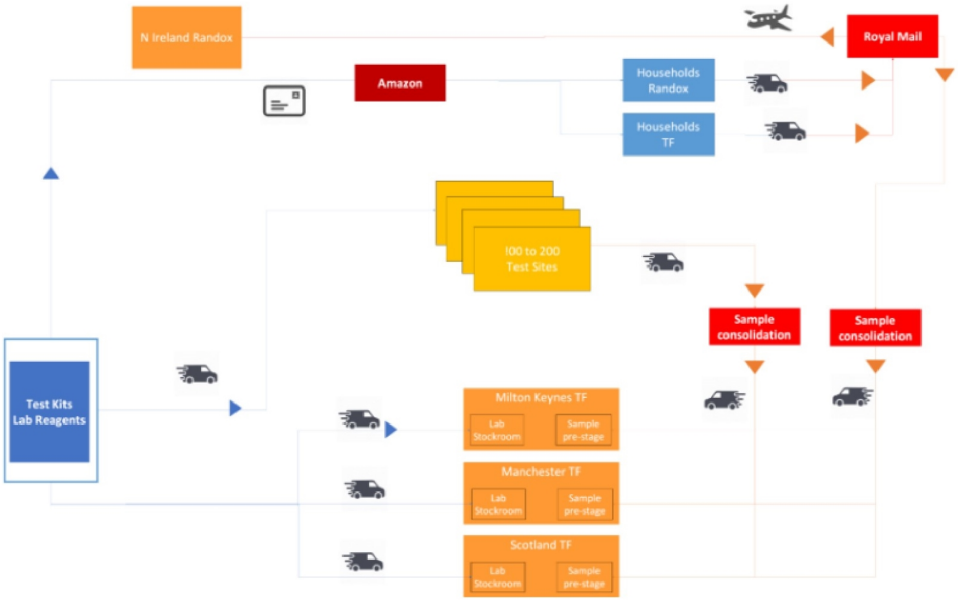
iv. Secure a supply of antibody LFTs to test the public with the aim of understanding immunity among the UK population. The Secretary of State gave us a mandate to spend up to £100m to secure supplies.

56. To deliver we had to prioritise the identification and sourcing of PCR reagent test kits, equipment and other testing consumables from both domestic and international suppliers. As I set out in my email sent on 18 March 2020 at 9.09pm to Kristen McLeod and others, my priority was *"tomorrow [will be] to engage with all parties to start discussions on formalising the arrangements with a focus on sustainability of the supply chain."* See [BJA/73 - INQ000535744].

57. I also refer to my email sent on 19 March 2020 at 16.19, in which I stated *"Key next steps, "**Anna** will create a spreadsheet detailing the current list of 6 suppliers along with additional product suppliers who currently sit outside the list but are deemed viable options. The headings will include, manufacturer name, manufacturer contact details, distributor name, distributor contact details, volume they can supply, minimum order quantity, lead times and a checklist of product specification etc. product dimensions, any specific storage regime (e.g. temperature control or specific transport requirements), cost per unit, any discounts, standard terms and conditions). We need as much of this information populated by tomorrow morning but at a minimum we need to understand the volume they can provide, the specification and unit cost. **Sharon**, I believe you have the specifications for the 6 currently on the list. Please can you send to myself, Pam, Phil and Anna asap as we need them for audit trail and also to provide Amazon and Boots with the information as they will be delivered to their warehouses. Amazon will be the delivery point in the first instance and they are going to send us the minimum information requirement they need on inbound products **(Phil can you chase on this please) Ed** once Anna sends you the spreadsheet can you populate with any information you have on the suppliers you have information for please."* See [BJA/74 - INQ000535751 and BJA/75 - INQ000535752].

58. My strategy was also to identify the individuals who came within keyworkers for mass antibody testing. I refer to my email, [BJA/76 - INQ000535735 and BJA/77 - INQ000535733].

59. As to my strategy for the distribution of LFT and PCR testing equipment, I do not consider it possible to separate out 'logistics' as it was all part of the end-to-end supply chain and was closely linked with supply and procurement. I did not influence what was sent, in terms of distribution between hospitals and care homes. See visual below that indicates the logistics involved in distributing test samples and test supplies covering the third-party laboratory testing end to end process [BJA/18 - INQ000561740].



60. My strategy adapted in April 2020 in that I increased focus on alternative testing technologies and point of care solutions. This included the possibility of using direct and RNA LAMP testing for different use cases, which involved further research on LAMP that led to two pilots. Point of care solutions increase accessibility of testing as they do not require a laboratory for processing and have shorter processing times although the devices are generally low volume.

61. The Covid-19 diagnostic testing strategy developed further from May onwards as increasing targets for daily testing capacity were set. For example, once a capacity of 100,000 was reached the objective was updated to increase the daily testing capacity to 200,000 by the end of May 2020 and to that end this was achieved through an increase in lighthouse lab capacity, increased use of commercial testing facilities (i.e. third-party laboratories who could provide flexible surge testing capacity) and further growth in capacity within the NHS.

62. My procurement strategy adapted in April 2020 references Covid-19 antibody testing when it was clear the antibody (as distinct from the antigen) LFTs were not fit for purpose: some were faulty and all were unusable. There was still motivation to ensure a test for antibodies was available and Tamsin Berry selected the consortium Abingdon Health to develop an antibody LFT initially through a grant, followed by a contract which my team negotiated. For high sensitivity detection of antibodies, ELISA antibody tests were established and my Commercial team negotiated terms with manufacturers of the assays (led by Lucy Mason) and third-party laboratories to deliver end to end ELISA testing (led by Audrey Wignolle).

63. In July/August 2020 my strategy further adapted in that I assisted in the diversification of testing technology to deliver mass testing to include those who are asymptomatic (known as Operation Moonshot) and provide increased access to diagnostic testing in preparation for the winter months, increasing supply chain resilience through having alternative testing modalities in addition to providing solutions that could deliver multiplex testing (e.g. testing for multiple viruses in a single process.

F. MY ROLE IN PROCUREMENT

64. The Commercial leadership role I held meant I had overarching accountability for the Commercial team. My approach to working with my team was to empower them / provide autonomy to make decisions and support them as required in their negotiations and other commercial steps. while making it clear I would provide cover for accountability as we were making high risk decisions. However, they were doing work that was complex and often more than would ever have been expected of them under more normal circumstances so I would ensure they engaged me to support as a point of escalation when dealing with particularly difficult situations or if they just needed some support. This meant I got more involved in the detail of some procurements versus others.

65. I should make clear that my role and that of the Commercial Team was, from a commercial perspective, to follow and deliver on the decisions which were made by policyholders and others as to procurement. Neither my team nor I had a role in making those decisions about, for example, the volume of product we purchased, the priority we gave to it, or the urgency with which it was purchased. Our role was to implement those decisions made by others and therefore to deliver on how things were purchased as a result of the decisions we were given. Whilst we were proactive and would take the initiative to identify and suggest solutions, where we did so we

suggested them to those who were making the decisions and they would consider them and remake the decision if that seemed appropriate to them. The first target relating to testing scale was to reach a daily testing capacity of 100,000 by the end of April and this had been decided before I was deployed into DHSC and announced publicly very quickly soonafter. From that point new targets emerged and while others in Supply Chain may have been consulted, I was never consulted from the standpoint of feasibility of securing those volumes. I was often given sight of target capacity numbers through minutes being shared [see exhibit BJA/78 - INQ000563075 - minutes from Prime Minister led meeting with NHSTT] and through membership of forums like the Lab Capacity Board [see exhibit BJA/79 - INQ000563077 and BJA/80 - INQ000563078 which mentions the path to 800k daily testing capacity and BJA/80 - INQ000563078 – the Winter Strategy document]. While I appreciate it was challenging for everyone to anticipate what would be needed from the outset, the 'moving of the goal posts' as I saw it did not help in enabling the efficient scale up of requirements. In the early weeks, DHSC Ministers did exercise caution in holding off making announcements until we had secured supplies, but while there had always been consistent engagement with No. 10 from the earliest days of my deployment, from July onwards, No.10 became more involved in driving decisions and strategy particularly in reference to mass testing [exhibit BJA/81 - INQ000513322 - I have included an email exchange between Gila Sacks and Imran Shafi, Private Secretary to the Prime Minister as an example which I also reference later in the section on Asymptomatic Testing]. This would sometimes lead to contradictory decision making between NHSTT and No. 10 [refer to example in paragraph 24]. By Autumn 2020, targets from No.10 were changing weekly and at times daily which led to increased requests to significantly increase volumes of tests across multiple methodologies (ePCR, LAMP, LamPORE, LFTs, PCR etc.). Some of these demands meant that suppliers needed to significantly invest in capacity which led to us having to make volume commitments with limited flexibility, the impact of which I believe led to contractual disputes later down the line e.g. LamPORE.

66. Aside from Pamela Doyle and Tim Byford who led pillars we also had other extremely experienced commercial professionals in the team who could confidently lead negotiations and would also support team members with less experience. We would have daily stand-up meetings to discuss progress on actions and we would often include Legal, Finance and Supplies in these forums. Legal were particularly closely

embedded in our team and we received excellent support from GLD for the first few months before they were replaced by external legal advisors.

67. We would also utilise priority action and contract trackers, see [BJA/82 - BJA/82 - INQ000535829 and BJA/83 - INQ000535771] for visibility. We also had regular informal drop-in sessions which were used to provide a supportive network and to check if people were doing ok as people were working extremely long days under immense pressure.

68. I have summarised below some of my key involvement in milestone procurement decisions that had been made. [BJA/84 - INQ000535892] provides a detailed overview of contracts placed throughout 2020 including spend value (see examples screenshot).

69. In March 2020 I initiated negotiations with UK Biocentre and Randox, which I handed over to Tim Byford to conclude. Tim and team members in Pillar 2 led negotiations with Serco, Boots, Sodexo and Amazon etc. Pam Doyle led the antibody lateral flow antibody activity supported by members of the team and I got involved in some of the negotiations as needed. I focused a lot of attention on procuring PCR equipment and consumables e.g. swabs, viral transfer media, tubes and RNA extraction reagents. The team would keep me informed on progress and escalate particularly contentious issues. We worked collaboratively as a team, and this shaped our working approach for the duration of my time in NTP/NHSTT. I always ensured to provide support as needed and provide cover/accountability for decision-making.

70. In April 2020 the procurement decisions/negotiations I was most involved in were Thermofisher, Hologic, Novacyte and the Oxford Nanopore (BGI kits). A lot of my focus was on assessing LAMP and shaping the scope of the pilots.

71. In May 2020 the negotiations I was most involved in were LAMP, point of care testing solutions, AstraZeneca and Abingdon Health.

72. In June 2020 the decisions/negotiations I was most heavily involved in were the business case development for the expansion of daily testing capacity and increased third-party lab provision, as well as the initiation of negotiations to increase volumes across the NHS and lighthouse labs which involved procuring more PCR platforms, tests and consumables from several suppliers (which included Thermofisher). Other areas of focus were concluding the LAMP pilots and the business case/negotiations on LamPORE.

73. In July 2020 the decisions/negotiations I was most involved in were concluding contracting with ThermoFisher and others for the increased volumes which had been initiated in June, LamPORE, and working on the expansion of the business case to extend to a daily testing capacity of 800k. I also worked with Emma Stanton, Alex Cooper, No. 10 and others to establish Project Moonshot.

74. In August 2020 the decisions/negotiations I was most involved in were LGC (piloting of new technology for End Point PCR (ultra-high throughput PCR), who were particularly challenging to deal, and working with Emma Stanton on the triaging of potential suppliers to deliver mass testing. I met virtually with the Rockefeller Foundation and they shared their insight of all global potential mass testing solutions. Commercial expanded on the database of information provided by the Rockefeller Foundation. Much of my time involved onboarding of the significant influx of resources which involved knowledge transfer and allocation of work.

75. In September 2020 the decisions/negotiations I was most involved in were LAMP with Optigene and LamPORE with Oxford Nanopore and Primer Design. I transitioned away from having Commercial oversight over all areas and switched to focusing on Project Moonshot/Mass Testing, for example antigen LFTs.

76. In October 2020 the decisions/negotiations I was most involved in were the significant purchase of antigen LFTs and the University Hospital Southampton LAMP lab.

77. In November 2020 I continued to support on Mass Testing priorities but I focused on handover to Jacqui Rock's new leadership structure, as I had in September 2020 informed Jacqui of my intention to leave at the end of December 2020 (although I later agreed to stay in an advisory capacity part time from January 2021 to March 2021 for around 0.5/1 day per week on an 'as needed' basis). My involvement in decisions/negotiations was therefore reduced.

78. It is not possible to set out the individual advice received for every single individual commercial decision as set out above and as detailed in the contract register [BJA/85 - INQ000561763]. However, our buying decisions were informed by instructions from Ministers, SROs, Number 10 and the Supplies Director in the main. My colleagues and I would sometimes challenge the directions given. For example, I strongly opposed the instruction to purchase 3 million BGI PCR test kits via Oxford Nanopore. I had an issue with the cost proposed (which they reduced) and the volume (I had concerns that we would not utilise this volume of kits given their limited compatibility with our existing PCR equipment estate). Despite the supplier making an 'irate' call

to complain about my challenging their offer, referring to my efforts to ensure the responsible spending of public money as 'haggling' (refer to email thread [BJA/86 - INQ000561737]), the Minister accepted my recommendation to reduce the volume purchased to I&S PCR test kits. This intervention resulted in a cost avoidance saving of £61,922,833. Another example is when I challenged the decision to award a contract to an entrepreneurial start up the Supplies Director was motivated to invest in through direct award of a contract. Among a list of reasons and risks I reiterated that *"[the supplier] have no proven track record. They have not delivered a Testing solution to a single customer... and their offering isn't sufficiently unique that other providers in the market would not be in a position to offer a similar solution..."* - see [BJA/87 - INQ000535854, BJA/88 - INQ000535853, BJA/89 - INQ000535855]. I do think it's important to acknowledge that my team and I often had more autonomy in driving the procurement decisions being made, sometimes in absence of instruction. For example, we often initiated/led the development of business cases and submissions which normally in business-as-usual circumstances our role would be to input into them or clear but not own.

G. INDUSTRY ENGAGEMENT

79. My team's general approach to contracting was as follows:

a. Pre-contractual validation processes: Testing technologies had to either have CE-IVD status or be working towards achieving this accreditation. They were also put through technical evaluation and assessed in accordance with protocols documented and published on the .gov website. Scientific leadership on technical evaluation came from Dame Professor Sue Hill and Sir Professor John Bell. Depending on the technology, some were tested and validated across multiple laboratories.

b. Use of letters of intent: Letters of intent were used sparingly and to secure supplies generally under circumstances where the supplier did not have an existing relationship with us; where there was a significant demand and there was a genuine risk to supply; or where there were long lead times that could lead to unacceptable delays in deployment.

c. Use of frameworks: Where feasible we would use existing frameworks which included but was not limited to the following:

i. NHS Supply Chain frameworks including those within the existing Category Tower structure

ii. PHE Microbiology Framework

iii. Crown Commercial Services Frameworks.

d. Unfortunately, as most of the existing frameworks were in place prior to Covid this led to constraints that limited the use of these frameworks: The capped values set for frameworks were at risk of being breached from single contracts placed which would essentially render the framework redundant. While suppliers already listed on frameworks were sometimes able to register new testing solutions to be added to the framework, much of the testing technology was an innovation from suppliers not on existing frameworks. Legally new suppliers are not allowed to be added during the lifetime of the framework unless set up as a dynamic purchasing system.

e. Direct awards. During the pandemic, direct awards were used more frequently than they would be in a business-as-usual environment because of the urgency. However, as I have mentioned, the Commercial team worked closely with GLD for the first three months and later external legal counsel. They were very much embedded within how we operated as a team. For all new contracts we would assess justification for the use of regulation 32 against the clearly set criteria. We always engaged legal colleagues in this process. This assessment was sometimes documented as part of the audit trail but not always as often it was very clear cut that the requirement fulfilled all the criteria for justification so written legal advice was not required. However, if there was ambiguity or partial justification which would indicate a medium to high risk of challenge then the legal advice would be documented and shared with key decision makers so that they could make an informed decision.

f. Key performance indicators in contracts: Where possible standard DHSC Terms & Conditions were used to ensure the appropriate key performance indicators (KPIs), and service level agreements (SLAs) were incorporated into the contract. Any deviation from standard would be subject to scrutiny by Commercial, Legal, Finance and Operations.

g. Protective clauses in contracts (e.g. refunds, termination for lack of quality provisions etc).

80. Whilst the default position was to utilise standard DHSC Terms & Conditions which includes clauses for termination rights, where appropriate, clauses would be

amended or additional included. For example batch control checks were included in the antigen LFT contracts. Also, where contracts were signed prior to completion of the technical validation or CE-IVD accreditation, termination rights were included if they failed to attain the relevant validation or accreditation within a set timescale agreed by contract.

81. I tasked a member of my team to set up a Contract register, which included details of all contracts, "*Hi Anthony, Steve (copied on this email) is on day 2 so has just started working on pulling together our contact register. I've mentioned how we would like to develop a sheet relating to contract volume roll out figures that would be populated by your team*"– see [BJA/90 - INQ000535852, BJA/91 - INQ000535805 and BJA/82 - BJA/82 - INQ000535829]. I also relied on the Direct Award guidance, the procurement urgent requirements document, the COVID-19 Commercial Guidance Direct Award and Extreme Urgency issued on 18 March 2020, [BJA/93 - INQ000496695] and the Procurement Policy Note [BJA/94 - BJA/94 - INQ000048822]. On 25 August 2020 a Powerpoint presentation was shared following induction training I delivered; "Commercial Induction V3" which was used for onboarding contractors and consultants. Multiple supporting documents were also shared summarising processes and providing templates. See [BJA/95 - INQ000535841, BJA/96 - INQ000535842, BJA/97 - INQ000383549, BJA/98 - INQ000535844, BJA/99 - INQ000383553, BJA/100 - INQ000535846, BJA/101 - INQ000535847, BJA/102 - INQ000535848, BJA/103 - INQ000383557, BJA/104 - INQ000383550, BJA/94 - BJA/94 - INQ000048822].

82. My approach to industry was to engage with the current supply chain including those not currently supplying but included on existing frameworks as referenced above and to align with Pillar 5 National Diagnostic Effort. This was launched via an Industry Webinar attended by circa. 500 life science suppliers held on 8 April at which I presented. The following documents detail the Submission launching Pillar 5 which provides detail of approach to engaging industry including the triage process of offers, [BJA/19 - INQ000535762]; a list of organisations we were engaging with and details of referrers, [BJA/106 - INQ000561751]; Stakeholder Management Report which provides detailed inside of how VTAG and New Testing Advisory Group ("NTAG") would triage offers, [BJA/107 - INQ000535819]; example email of how referrals went through VTAG (Viral Test Advisory Group), [BJA/108 - INQ000535799]; the agenda for National Diagnostic Webinar which I was a speaker,

[BJA/109 - INQ000535754 & BJA/110 - INQ000535755]; and the slides I presented, [BJA/111 - INQ000535756 & BJA/112 - INQ000535757].

83. I engaged directly with the Rockefeller Foundation who were introduced to me by William Warr. Following discussion with scientists specialising in mass testing at the Rockefeller Foundation in New York they kindly shared a spreadsheet with me which provided a comprehensive list of global suppliers who could supply or were in the process of developing testing technologies likely to be suitable for mass testing. This consisted mostly of LFTs, LAMP and point of care testing devices. As a starting point I assigned tasks to my team to do some engagement with those on the list we were not yet familiar with to obtain more insight to their solutions [refer to relevant documentation: [BJA/113 - INQ000535828, BJA/114 - INQ000563080 and BJA/115 - INQ000535832] - Introduction to Rockefeller Foundation by Will Warr (SpAd). Only Will Warr and I attended the meeting when it went ahead. Call was 3pm 23/07/20. [BJA/116 - INQ000535838] - Paper from Rockefeller Foundation on National Covid-19 Testing Action Plan Pragmatic steps to reopen our workplaces and our communities. [BJA/117 - INQ000535839] - Mass testing products and suppliers database shared by Rockefeller Foundation. *"- COVID Testing Commons: This is the testing database that I mentioned - 1477 tests on the market or in development to date. You can find it on-line at testingcommons.com You can search the database directly on a wide variety or parameters. I have also attached the worksheet with the UK based companies highlighted."* [BJA/118 - INQ000535831] - Paper shared by Rockefeller on value of surveillance testing. [BJA/119 - INQ000535840] - Email thread on Mass Testing and engagement with scientists and researchers. [BJA/120 - INQ000535836 / BJA/121 - INQ000535837] - Development of LFT market overview utilising data from Rockefeller. Formed the basis of the triage process we put in place to identify suitable LFTs. [BJA/122 - INQ000535835] - Email exchange with Professor Sue Hill offering to introduce her to Rockefeller (which I did) and the authors of the Bohner Paper.

84. The list with the additional information we had gathered was shared with Dr Emma Stanton, Director of Innovation and Testing Supplies who stood up a team which utilised existing Supplies Team members, Commercial (including me and members of my Commercial Team) and Consultants from PA Consulting and McKinsey.

85. Following further information collection from suppliers, the list was ordered by priority based on how well they fulfilled certain criteria relating to technical specifications and

potential use case suitability along with cost effectiveness and ability to deliver testing capacity at scale.

86. Calls were arranged with these suppliers, led by Dr Emma Stanton and her Team and supported by Commercial who were present on all calls. Actions to progress were triaged through the Design Authority Reviews (DAR) set up to ensure all key stakeholders had input into deciding next steps and whether to progress a solution. This provided an audit trail of decision making that allowed us to also provide feedback to suppliers.

87. PA Consulting chaired the DARs and McKinsey maintained the database of activity. The focus was engaging with suppliers not previously known to us although we also reviewed others through this process who had progressed in their development since previous engagements.

88. It is not possible for me to list every single supplier I had direct engagement with as there were many. I have referenced in the timeline some of the suppliers I was most engaged with which included ThermoFisher, Optigene, AstraZeneca, Hologic, Oxford Nanopore etc. I also engaged with many suppliers we assessed as part of our triage process, some of whom were successful in being awarded contracts and others who were not e.g. ScaleDX, FRANKD, Yoti, GeneMe, NEB, QuantumDX [email referring to QuantumDX who I engaged with on several occasions BJA/123 - INQ000535879 etc].

89. We received many referrals of potential suppliers to NTP/NHSTT. All contracts were based on whether from meeting the strict technical and scientific criteria the items were fit for purpose. This and the fact that we had limited options (due to the fact that there were only certain technical consumables that were fit to be used on our existing state anyway) were factors which I consider meant we were able to minimise conflicts of interest. Contracts were progressed by triaging and prioritising the evaluation of suppliers based on need and technical specificity/compatibility. All contracts were evaluated according to the science, namely whether they met the strict scientific criteria. All contracts were negotiated by Commercial. Civil Servants provide an annual declaration listing any conflict of interest. Due diligence was carried out on contracts and also on contractors and consultants, ensuring a Commercial Civil Servant had oversight prior to the signing of contracts. This helped in limiting exposure to this risk.

90. I have been asked by the Inquiry to comment on the nature of disagreements (and the resolution of them) between me and members of my team and the policy team (including Tamsin Berry,) as taken from a reference in an email which itself is referred to in the judgement of Mr Justice Waksman in the case of Good Law Project Limited v The Secretary of State for Health and Social Case and Abingdon Health Plc. I received this email at 12.17 on 30 April 2020 [BJA/124 - INQ000535778]. I was not a direct recipient of it and do not recall seeing it, but it appears that it was forwarded to me on 30 April 2020 by Tamsin Berry. This then caused me to send an email at 13.29 to Andrea Barry, in the following terms:

"Hi Andrea,

I just wanted to give you sight of a storm brewing in regards to the Abingdon Consortium. Today was the first day Commercial had been invited to even speak to the Consortium and because we wanted information to understand what the commercial construct should be we are getting accused of being difficult and obstructive. Do you have sight of what has been agreed and signed off on this with the Treasury. It's another example of Commercial being involved too late and then just expected to rubber stamp arrangements. The tone of the emails are also inappropriate." [BJA/125 - INQ000535777].

91. The background to the email and the 'storm', the disagreement, was that members of my Commercial team which included Christian Destombes, Jean-Yves Rotté-Geoffroy, Alex Heuser and Sam Richman along with colleagues from Finance and Legal were invited to meet Abingdon Health Plc for the first time with Tamsin Berry on 30 April 2020. The agenda is documented [BJA/126 - INQ000535773 / BJA/127 - INQ000535772]. My team had not previously had any direct engagement with Abingdon Health. Our involvement had only been by way of email in the previous weeks as to the overall situation with Abingdon Health and that it had been awarded a grant for £2.5 million in respect of research for developing a prototype LFT testing kit along with the UK-RTC (Rapid Test Consortium). This was part of the national programme of antibody testing to enable individuals to determine whether they had been exposed to the SARS virus and to collect a national dataset of immunity.

92. I refer by way of example to [BJA/128 - INQ000535761] an email on 20 April 2020 at 21.26 from me to Andrea Barry, making clear that the Commercial team would require value for money in respect of any contract; and also [BJA/129 - INQ000535774] which were emails on 28 April 2020 as to the process of approval, namely that the Commercial team would have to approve any contract.

93. During the meeting Tamsin Berry instructed my commercial colleagues to draft a contract ready for signing with Abingdon Health by the end of the day. They said this was not possible and further due diligence would be required as well as negotiation. Tamsin Berry texted me after the meeting to say the meeting was embarrassing and she blamed my team.

94. The follow up email thread was negative in tone [BJA/125 - INQ000535777] and unreasonable in its demands: *"This is mission critical to sort TODAY. We have been talking about this for 3 weeks – I have email trails with Steve Oldfield who advocated this approach...We MUST agree how to transact and recoup costs when we do the pricing agreement." "I appreciate that it is not easy when being asked to work outside what would be considered the 'normal process'. That said, that meeting was quite frankly embarrassing. It looked like we were not aware of the ask (which is bad enough) but to do so in front of a consortium that UK Government is supposed to be backing to meet our demanding targets was far worse. We are asking these guys to work at pace and at risk to be (quite possibly) the first people in the world to develop an antibody test for at home use. And yet we gave the impressing of impeding and making life difficult rather than being there to help... Before we have any further conversations with them we need to agree what our proposed way forward is. This needs to be done immediately, for as Tamsin said, we do not want to be going to SoS over the weekend to say that the delivery of antibody testing is being pushed out because of this, when CST approved the principle of funding this on 20 April. If you do not think you are the right decision maker on this then you need to escalate it today and involve the right people. The consortium are highly likely to raise this with the minister today and he will want an update..."* I did not reply to the thread as it was unlikely to lead to a constructive conversation or a resolution, my preference being to have a meeting to discuss the issues.

95. I therefore arranged a meeting for later on 30 April 2020 with those who had attended the meeting from my team and Tamsin Berry and her colleagues as well as Legal and Finance. I explained that our role was not just to churn out contracts with no prior engagement or due consideration and we had concerns with the arrangement. I also explained that respectful collaboration, kindness and professionalism was important if we were going to be able to work effectively together. We agreed next steps and actions which included my team working up Heads of Terms for the contract and also that we would assess risk and put a recommendation in terms of our approach to negotiation to Minister Lord Bethell in a submission.

96. I refer to document [BJA/130 - INQ000535776] which are further emails which passed later on 30 April 2020 between me and Andrea Barry.

97. I also refer to document [BJA/131 - INQ000535775] which is an email sent in the evening of 30 April 2020 showing the due diligence which was required by my team before a contract could be approved.

98. On 1 May 2020 Christian Destombes of my team sent an email which set out proposed Heads of Terms of a contract between DHSC and Abingdon Health Plc [BJA/132 - INQ000535781] and document [BJA/133 - INQ000535780] which shows that Commercial rapidly worked to progress the draft contract just the next day after the meeting. I commented "*Well done on turning this around so quickly*'."

99. As agreed with Tamsin Berry and Sam Roberts, to ensure the Minister had full sight of the risks, before concluding the contract, we provided a submission detailing our concerns including risks as set out by Legal that required consideration before progressing [submission BJA/134 - INQ000535782 and follow up clarifications BJA/135 - INQ000535783]. This was followed up by two meetings to discuss risk mitigation the second of which included David Williams at the request of Minister Lord Bethell [BJA/136 - INQ000535786, BJA/137 - INQ000535787, BJA/138 - INQ000535785 and pre-meeting email exchange with team, BJA/139 - INQ000535784].

100. Despite the issues my team and I were able to successfully conclude the contract and relations with Tim Brown and Tamsin Berry significantly improved [BJA/140 - INQ000535795, BJA/141 - INQ000535794, BJA/142 - INQ000535793].

H. DEVELOPMENT OF TESTING EQUIPMENT

101. I have set out earlier in this statement the detail and purpose of the meeting on 18 March 2020, and I have referred to and exhibited all the documents I have regarding my invitation to, participation in and contents of the meeting.

102. At the meeting it was quickly established that we were in a crisis and needed to radically increase our C-19 testing capacity and capability. It was noted that the entire capacity across the NHS (and PHE) was only around 2-3000 tests per day at best and we would need to rapidly scale up to a daily testing capacity of 6 figures. Later on 18 March the target of 100,000 was set with a deadline of the end of April 2020 [BJA/143 - INQ000535750].

103. The context in which we were operating is important to consider. This was a global crisis and in terms of testing capability there was only one widely acceptable 'Gold standard' testing methodology available at the beginning of the pandemic: the PCR. Almost immediately it became apparent that this would pose a significant issue in being able to build testing capability and capacity at the scale needed. My own insight into laboratory processes and my initial assessment of the supply chain increased my awareness of the enormity of the challenge:

    a. PCR is routinely used in diagnostic and research laboratories but generally on a small scale. Equipment takes up space, can be costly and requires qualified technical personnel to process the test. It's a technique that was not developed to process at the significant volume and scale needed to respond to a pandemic.

    b. Global demand for supplies and equipment substantially outstripped supply and capacity.

    c. Supply production capacity was itself impacted by the pandemic, caused by lockdown, closure of production facilities in China, availability and accessibility to raw materials.

    d. There were complex and restrictive supply chain requirements, given:

        i. the timeframe for sample degradation limited logistics options;

        ii. some reagents required cold-chain transport and storage; the competing demand for reagents (for example ethanol was used in Testing but also used in sanitising products where demand increased);

        iii. the variation across testing protocols (for example some had a bill of materials (BoM) of circa. 50 items. The BoM refers to the total number of items needed to process a single PCR test, everything from pipette tips, to RNA extraction media and all other consumables but excluding labour.

        iv. the lack of availability of qualified personnel (laboratory technicians);

        v. technical compatibility: the trend across the NHS had been to opt for PCR equipment that was brand specific in that only specific reagents and consumables were compatible for use with the PCR

machine. The NHS had become increasingly reliant on large global suppliers. This significantly limited supply options. Even swabs (e.g. break-point to prevent nasal damage from sample collection) and viral transfer media (e.g. solution type as some posed a health and safety hazard in the case of spillage) had tight technical specifications.

104. The phone calls with OLS were because they set-up the Testing workstreams under the direction of Minister Lord Bethell.

105. The key developments in the diversification of Covid-19 testing technology with regard to LFT and PCR testing were:

    a. DNA Nudge, Samba II and Optigene LAMP Genie II and Genie III [April 2020] - these were point of care/near care solutions used to triage patients presenting at A&E with symptoms. DNA Nudge and Samba II were also used to test NHS staff when Trusts needed a fast turnaround to prevent unnecessary staff absence. Note that DNA Nudge and Samba II had sensitivity and specificity on par with RT-qPCR. Direct LAMP (the rapid procedure that excludes the RNA extraction step) has reduced sensitivity compared to RT-qPCR but equitable specificity. LAMP that includes the RNA extraction step which lengthens the process has specificity and sensitivity on par with RT-qPCR.
    b. LamPORE, new technology developed by Oxford Nanopore [in June 2020] - high throughput testing solutions with sensitivity and specificity on par with RT-qPCR. This offered a near care solution.
    c. LGC - piloting of new technology - End Point PCR (ultra-high throughput PCR).
    d. First technical validation of lateral flow tests [September 2020].

106. The key developments in the expert advice with regard to LFTs (antibody and antigen) and PCR testing equipment were:

    a. April 2020 the COVID Testing Scientific Advisory Panel concluded that the specificity and sensitivity of the procured antibody LFTs did not pass validation.
    b. Between March 2020 and June 2020 the majority of senior scientific and medical advisors were of the view that PCR was the only suitable diagnostic

methodology for Covid-19. The policy at the time was to only test individuals presenting with symptoms. There was little appetite to consider lower sensitivity rapid tests or the testing of asymptomatic individuals. This began to change following the asymptomatic testing pilots which are covered later in this statement as it led to the acceptance that asymptomatic individuals posed a transmission risk and that there was a positive use case for lower sensitivity tests as a means to reduce infection rates and move towards reopening society.

c. Diversification of testing methodologies was driven by the need to deliver the volume of testing capacity required for Winter, improve sample to result turnaround times, broaden access to testing capacity to fulfil different uses cases and to build resilience in the supply chain. Refer to [BJA/144 - INQ000535818 - SARS-CoV-2 and Viral Respiratory Testing Strategy, Winter 2020].

I. LABORATORY TESTING

107. I have set out earlier in this statement the detail and purpose of the meeting on 18 March 2020, and I have referred to and exhibited all the documents I have regarding my invitation to, participation in and contents of the meeting.

108. As I have set out above, I set up the Commercial Team ensuring resources were deployed to support the various Pillars, two of which from the outset were lab-based testing, both NHS and Third Party. I appointed commercial CTT individuals Phil Newman and Tim Byford and they reported to me in terms of the commercial work being delivered (all CTT personnel retained links with their regular reporting lines within CTT). Pamela Doyle led pillar 3 (antibody LFTs). It has already been referenced earlier in the statement that as more team members were onboarded they were allocated to work within and across pillars. For example, Anna Slominska initially worked in pillar 1 but soon transferred to working on pillar 3 and Alicia Caley worked in pillar 2. Phil and Tim would update me frequently. In turn, I reported to No. 10 daily, for the first four weeks, to Ministers in DHSC multiple times during a day in the early days reducing over time to daily and then as required as we established more sustainable capacity and I also kept CO updated (Gareth Rhys Williams and Lord Agnew on a daily basis as referenced elsewhere in this statement). While DHSC Commercial Director, Melinda Johnson was not involved in NTP/NHSTT we had regular catch ups, and I also shared the daily updates I sent to Cabinet Office with her to keep her informed.

109. As set out above I had overall responsibility and accountability for the commercial delivery, for all three initial Pillars (and all five when they expanded), but did not individually lead the Pillars except for a period when Phil Newman was transferred from Pillar 1 to work in Pillar 2 and I provided cover as lead. However, trusted and highly experienced peers Tim Byford, Pamela Doyle and Lucy Mason also provided additional leadership to the team which helped my workload in not being spread too thinly. As noted earlier, I was lucky that several others working within our team were also highly skilled and experienced which was valuable in ensuring some of our less experienced colleagues had support around them. My activity regarding testing technology as a leadership role went beyond commercial and I engaged extensively with industry, academia and medical and veterinary science to rapidly test, validate and industrialise new and developing solutions, with the objective to support the Government's objectives to increase testing volume, speed (from test to result), lower cost and access to harder to reach social groups. Further, the whole Testing Commercial team worked collaboratively across all Pillars. We did not work in silos and the work was not mutually exclusive: individuals would be deployed to deliver contracts according to priority, so they would work across workstreams/pillars as needed. While the limited resources we had were inadequate and unsustainable in the context of the volume, pace and complexity of the work required of us, we built a strong sense of camaraderie as a team and being small meant it was easier to have sight of the portfolio of our work. This helped when issues were escalated to me as I could familiarise myself with the situation and understand the detail very quickly. I am very proud of the supportive culture my colleagues helped create and the phenomenal effort they made day in and day out often at significant personal cost to their own wellbeing.

110. I have noted elsewhere in this statement the supply/demand/capacity analysis and reporting work we progressed with the support of Deloitte. I include an email exchange from April 2020 [BJA/145 - INQ000535769] which I was copied on where Andrea Barry from Finance explains; "*we are struggling to get HMT over the line with a significant financial envelope as they are asking a lot of questions on supply and demand and the analytics to support the decision making – we would like to understand what data is out there, and what isnt and how we can work together to provide assurance to HMT ministers accounting officer etc that the decisions are backed by some form of data, and or that there are not and we are happy to go at risk*."

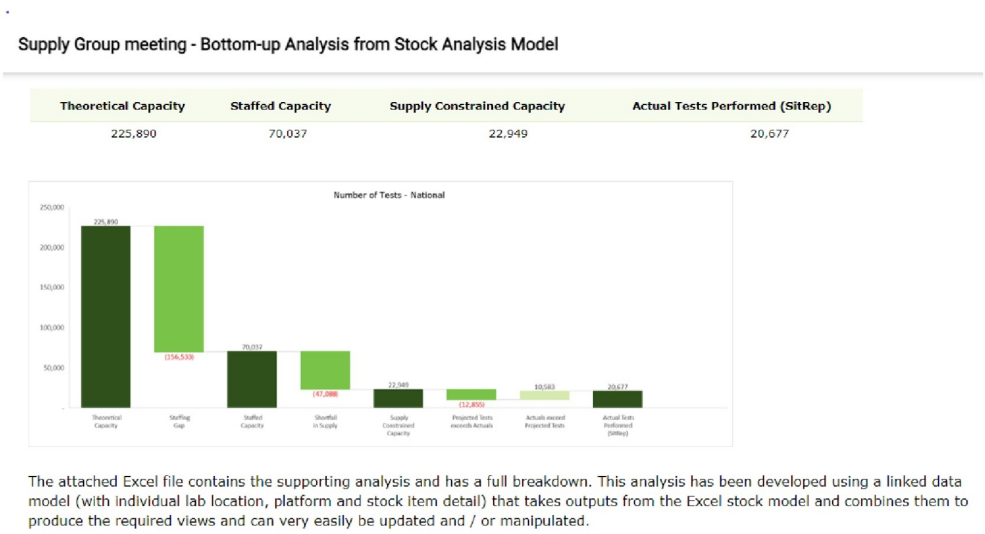
111. In another email exchange [BJA/146 - INQ000535760] it is noted that the calculations for supply were based on modelling provided by SAGE (Scientific Advisory Group for Emergencies) and PHE while taking into account the fragility of the supply chain; "*Indicative PHE modelling suggests that we need 750,000 tests per week (so just over 110,000 per day) to meet clinical and key worker demand. As we look towards exiting lockdown, we will need to create capacity to also test the wider population as part of the test, track and trace strategy. We therefore need to go beyond the 110,000 per day. SAGE are currently conducting modelling on these volumes*."

112. In terms of supply risk; "*Of the 100,000 tests to be delivered by the end of April, 97% of these will rely on reagents delivered by 9 major suppliers. Of these major suppliers: 65% of the 100,000 tests rely on reagents predominantly manufactured in the US by two suppliers (Thermofisher and Roche). There is some risk that export of these will be compromised. 15% of the 100,000 tests rely on reagents that have experienced issues with their supply chain (Abbott and Qiagen). Qiagen's most recent orders have been late or less than promised and Abbott has not had sufficient RNA extraction kits this week and likely next week as well. Given this, we have uncertainty around a large percentage of our supply chain, hence the desire to secure additional supply, particularly supply that is manufactured locally... there are doubts about whether Randox can scale up their capacity in the timelines involved*."

113. I think later in the year when we expanded into Mass population testing and building Winter Capacity, volume decisions appeared to be based less on demand modelling and were driven by No. 10 (although it is possible I may not have had visibility of the modelling underpinning the decisions being made). For information of further references to supply and demand modelling, I have included some email exchanges with Cabinet Office Controls when we were seeking approval for expansion of lab capacity to 500k tests per day by September [BJA/147 - INQ000535827], the business case [BJA/148 - INQ000561754], the request sent to HMT for approval [BJA/149 - INQ000535823] and example Lab Capacity Board Minutes [BJA/150 - INQ000535824].

114. This approach to supply and demand modelling may have changed over time but essentially we were provided with Testing capacity targets. The first was to get to 100,000 PCR tests per day by the end of April, which was achieved. The target was then increased to 200,000 and 500,000 tests per day. In terms of testing capacity, we would obtain this from the laboratories we were working with under pillars 1 and

2. Capacity was calculated based on the shift patterns of laboratory personnel, equipment capacity, supplies available and cycle times. Deloitte under the direction of Sam Roberts set up a reporting system to provide clarity of daily testing capacity within the NHS laboratory network [BJA/151 - INQ000535770, BJA/152 - INQ000535806, BJA/153 - INQ000535790, BJA/154 - INQ000535821]. Commercial worked closely with the supply chain director Dr Samantha Roberts and her team to understand the supplies needed - technical specification, volume, storage and delivery location. This was critical for us to ensure we engaged with qualified suppliers and could deliver suitable contracts. When Sam Roberts left NHSTT, I took on the SRO role to enable Ben Davies from Deloitte and his colleagues continue in refining the reporting system for understanding real time supplies and testing capacity within the NHS/PHE network [BJA/155 - INQ000535804, BJA/156 - INQ000535857]. The visual below indicates the challenge of matching actual capacity to theoretical capacity:



Taken from document BJA/153 - INQ000535790.

J. ASYMPTOMATIC TESTING

115. LAMP is a well-established diagnostic testing methodology for infectious diseases and is not dissimilar to RT-qPCR in its application. It is highly flexible in its application (the direct methodology provides a result in less than 30 minutes versus 90 minutes for PCR) and requires less equipment and specific conditions than PCR making it a low cost, flexible solution which can particularly suit developing countries and field work.

116. The main reason LAMP was less widely used and not seen as a 'gold standard' test like PCR is that LAMP historically carried a higher risk of contamination leading to false positives. LAMP, just like PCR and other nucleic acid amplification methods, works by making more copies of a specific segment of DNA based on a template of the same nucleic acid sequence. Billions of these copies are generated in a single, tiny reaction, leading to a fluorescent or colourful result that we can interpret. These copies of an original template that are generated through amplification are called amplicons: they are small DNA molecules, chemically exceptionally stable, much more than the RNA of a virus for example. In a true positive test, the DNA amplification commences based on the presence of a template sequence in the sample, the viral RNA. If, for some reason, a small amount of amplicons from previous finished reactions gets into the reaction tubes from whatever source, one will get a false positive reaction that was not triggered by the presence of a template sequence from the virus, but from an amplicon. In this case, a true positive cannot be distinguished from a false positive and the results are unreliable. LAMP was first described in a 2000 publication in the Nucleic Acids Research journal titled 'Loop-mediated isothermal amplification of DNA'.

117. I have summarised the sequence of events and my role in identifying LAMP as a potential route to mass testing in the following paragraphs but I also include exhibit BJA/81 - INQ000513322 which provides a more concise summary including key documents [BJA/157 - BJA/157 - INQ000498299, BJA/158 - INQ000563400, BJA/159 - INQ000563083, BJA/160 - INQ000563084, BJA/161 - INQ000563085, BJA/162 - INQ000563086, BJA/163 - INQ000563087, BJA/164 - INQ000563088, BJA/165 - INQ000563089, BJA/166 - INQ000563090, BJA/167 - INQ000563091 BJA/168 - INQ000563092, BJA/169 - INQ000563093], documented in an email sent to Gila Sacks who was the NHSTT Policy lead at the time in July 2020. At the beginning of April, a colleague in Cabinet Office drew my attention to a news bulletin that was going to appear on the BBC about how Hampshire NHS Trust was using direct LAMP to triage patients in A&E as they were able to detect patients with high viral loads of Covid in 20 minutes. They had struggled with long turnaround times for PCR results and this allowed them to isolate patients and treat rapidly. I watched this and obtained contact details for the individuals involved. After speaking with them I arranged for the scientists and representatives from Optigene, the provider of the tests and equipment to an introductory meeting with Minister Lord Bethell so they could explain how it worked and how they were applying its use in the hospital setting. The key action from this meeting was for me to write a brief paper on LAMP

and its potential use cases [BJA/170 - INQ000561741] which I shared on 22 April 2020 and 23 April 2020 with colleagues working on NTP to obtain feedback [BJA/171 - INQ000535763 and BJA/172 - INQ000535765] prior to submitting for review by NTAG [BJA/173 - INQ000535766]. I had prior to that shared additional information including a link to some of the press coverage [BJA/174 - INQ000535759] and information that was requested by Minister Lord Bethell's private office. I requested the standard operating procedures from Optigene which they sent [Documents BJA/175 - INQ000535764 BJA/176 - INQ000561742, BJA/177 - INQ000561743, BJA/178 - INQ000561744].

118. Separately Professor Keith Godfrey from the University of Southampton had approached No. 10 about doing a mass testing pilot using LAMP. SpAds Will Warr and James Phillips followed up with Kathy Hall to ask if we were doing anything to investigate LAMP. Kathy Hall then directed the query to Paul Chambers who worked in the Supplies team as she wanted to make sure we were not missing an opportunity. Paul disclosed the work I had already been doing on understanding the potential application for LAMP [BJA/179 - INQ000535768 – email thread].

119. At this point I was already working with the Hampshire scientists Veronica Fowler and Stephen Kidd on a potential pilot to extend the use of LAMP within A&E in the hospital setting while piloting the concept of a 'lab in a van' to provide an accessible facility to test individuals in care homes. On this basis, I picked this up as a lead and agreed to meet with Professor Keith Godfrey. In that initial meeting I was joined by Samantha Roberts. It was an interesting discussion as his proposal [BJA/180 - INQ000511334] set out the benefits of mass population testing of asymptomatics to reduce infection rates and expedite a route out of lockdown. However, the proposal was too ambitious for a pilot, but Samantha and I agreed that I would work directly with Keith to rework the proposal into a pilot of a smaller scale [BJA/181 - INQ000535800]. I worked on both pilot proposals in parallel both of which proposed using Optigene's technology and testing reagents.

120. A submission [BJA/157 - BJA/157 - INQ000498299] covering both pilots was submitted to ministers for approval, and they were also shared with key personnel in number 10 and among scientific and clinical advisors. While Ministers were supportive of the pilots "*Ministers have reviewed this submission and agreed to the work. However, the SofS questioned why the pilots were so small...*" - [BJA/183 - INQ000535789]. There was a delay in progressing due to some apprehension among medical advisors that included Sir Chris Whitty. Their concern was the ethics

around using low sensitivity testing methodology which would lead to some false negatives. Our counter position, was that asymptomatic individuals did not have access to Covid-19 PCR testing so would not have the opportunity to determine their infection status unless they developed symptoms. We also confirmed that we would make it clear to participants that a negative result did not mean they were not infected and that they should continue to follow government issued guidelines. I contacted SpAd James Philips to see if he could help in finding a resolution. He set up a meeting which unfortunately I was unable to join but Sam Roberts and Paul Chambers attended and were able to respond to some of the issues raised. There was still some apprehension and Sam Roberts put Sir Chris Whitty in touch with Professor Keith Godfrey directly with the CMO eventually confirming his approval for the pilot to go ahead on 21 May [see relevant email threads – BJA/183 - INQ000535789, BJA/184 - INQ000535788, BJA/185 - INQ000535791, BJA/186 - INQ000535792].

121. I carried out desktop research on LAMP through internet searches, reading of scientific papers and more broadly read epidemiology papers relating to disease transition to help deepen my understanding of the attributes needed for testing solutions that could deliver diagnostics on a mass scale. I also contacted scientists and academics working on LAMP to increase the range of perspectives of its benefits and limitations. I had also received other pilot proposals recommending LAMP as testing solution for wider population testing which I reviewed alongside our proposed pilots. Unfortunately, they were less well developed than the proposals from Hampshire and the University of Southampton which is why we did not progress the other options.

122. My role in both community-based testing pilots (e.g. the 'lab in a van' and asymptomatic testing pilot in Southampton) was that of a senior responsible owner (SRO) / supplier relationship manager supported by two of my team members, Bryony Gale and Jessie Crabtree. We worked with Hampshire NHS Trust and the Southampton team respectively to agree the scope of the pilots and facilitate with the supply of the equipment, tests, consumables and the van along with the kitting out of the van.

123. As previously noted, I drafted the submission for Ministers, secured the funds/budget to support, engaged my supplies and NTAG colleagues to gain their support and my colleagues Bryony and Jessie delivered the grant agreement. I also worked with communications colleagues to draft the press release and announcement to be

delivered by the Secretary of State. I also shared regular progress and the results of the pilots with key stakeholders which I have already referenced earlier in this statement [BJA/187 - INQ000563072, BJA/69 - INQ000535822, BJA/70 - INQ000535826, BJA/188 - INQ000535863, BJA/189 - INQ000535812].

K. PROCUREMENT OF LFT AND PCR

124. I always had a role in negotiation, but also often had to either lead on the development of business cases and/or submissions or overseeing others in my team taking the lead. Normally it would have been the SRO or Policy lead doing the development of business cases, but there were a lot of resource gaps, so we often had to take the lead. Commercial played a more active role than usual in scoping testing solutions due to our close engagement with the supply base who would share ideas and the academics/scientists we were working with. Calculations were based on volume required and estimated costs which we obtained through understanding existing costs and discussion/negotiation with the supply base. Progress on procurements was reported back to SROs across pillars, Ministers and the Supply Chain Director as well, Finance and often No.10 who wanted regular progress updates on procurements. Later on, reporting was expanded to the Test & Trace leadership team and to No. 10 as required.

125. I have referenced some example business justifications and ministerial submission documents. It is worth noting that a submissions and approvals tracker was set up on DHSC's exchange platform. I no longer have access but it should provide a complete audit trail for all submissions and approvals [BJA/190 - INQ000535876].

Document reference	Comments
BJA/191 - INQ000561747	Example email thread of process for gaining approval on Submission for Serology ELISA antibody testing (led by Lucy Mason from DHSC who was part of our Commercial team).
BJA/192 - INQ000561756	CO approval email thread for Business case HMGC5631 - Lighthouse Expansion.
BJA/193 - INQ000535865 BJA/40 - INQ000535870 BJA/39 - INQ000561757 BJA/194 - INQ000561761	Email threads relating to direction from number 10 to procure 200m LFTs and approvals and follow up activity to conclude negotiations and engagement with Legal.

BJA/195 - INQ000535873 BJA/196 - INQ000535864 BJA/197 - INQ000535869 BJA/198 - INQ000561758 BJA/199 - INQ000535871 BJA/200 - INQ000535867 BJA/201 - INQ000561759 BJA/202 - INQ000561760 BJA/203 - INQ000535872 BJA/204 - INQ000535866 BJA/205 - INQ000535868	
BJA/206 - INQ000535825	Business justification for Thermofisher supply to lighthouse labs and NHS.
BJA/207 - INQ000561750	Business justification for Thriva service provision of ELISA testing.
BJA/208 - INQ000561749	Business justification for Abbott PCR.
BJA/209 - INQ000535803	Submission for Lab Capacity – email thread.
BJA/38 - INQ000535833	Response to conditions set by Lord Agnew and Gareth Rhys Williams and Cabinet Office Controls in response to the Lighthouse lab expansion business case in order to obtain approval.
BJA/210 - INQ000561752	Example contract overview we would provide to DHSC colleagues who had delegated authority to sign contracts. We would also include attachments such as the contract (this one is for a Point of Care contract amendment with DRW).
BJA/211 - INQ000561753	Business justification for DRW contract amendment.

L. AWARD OF CONTRACTS

126. As I have set out above I led the commercial team which was part of the process for negotiating contracts, with Tim Byford and Pam Doyle also providing commercial leadership. In this we would be involved in all stages but not contract signing which was done by individuals with the appropriate delegated authority within DHSC e.g. Edward James or Lucy Mason and later Jacqui Rock. We would provide them with a contract recommendation report before signing. We would put contracts in place

under the instruction of the supply chain director and/or the SRO/policy lead for a particular pillar/Ministers and No. 10 (although we would challenge decisions when warranted, examples of which I have already provided in this statement). It all related to targeted daily testing capacity which later included mass testing.

127. Suppliers were identified through various routes:

    a. Existing supplier frameworks; while we could not award contracts via the frameworks for reasons stated earlier in this statement it was a good source of suppliers who had the technical credentials to deliver the supplies we needed e.g. PHE Microbiology framework, NHS Supply Chain Category Pillar frameworks.

    b. Through industry; as noted elsewhere in this statement we hosted a number of Industry webinars targeting life science companies with the potential to supply requirements. We also had offers of support from the Pharma Industry. For example, AstraZeneca and GSK were very proactive in sharing the contacts of their own PCR supply chain and would share any new sources they managed to identify.

    c. Through the triage system; there was a form on the Government website that suppliers could submit with details of their products, services and capability to support diagnostic testing. Offers were also shared from other parts of Government e.g. BEIS and via referrals from individuals.

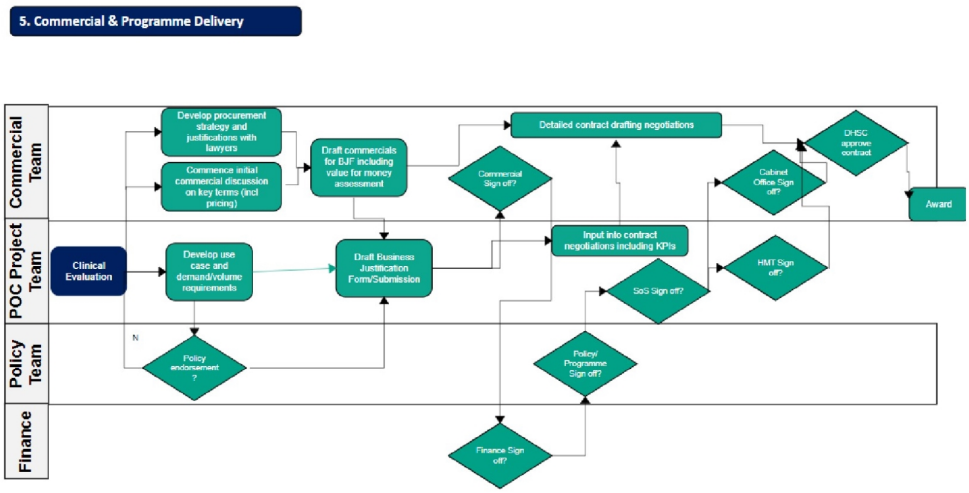
    d. Through the contacts from the spreadsheet provided by the Rockefeller Foundation.

    e. Through wider networks such as academic and health institutions.

128. Where possible standard DHSC Terms & Conditions were used to ensure the appropriate key performance indicators (KPIs) and service level agreements (SLAs) were incorporated into the contract. Any deviation from standard would be subject to scrutiny by Commercial, Legal, Finance and Operations.

129. The processes and governance of my team are documented in the Commercial induction training pack developed for onboarding resources. I include all the document references that formed part of the training and induction process for reference [BJA/95 - INQ000535841, BJA/96 - INQ000535842, BJA/97 - INQ000383549, BJA/98 - INQ000535844, BJA/99 - INQ000383553, BJA/100 - INQ000535846, BJA/101 - INQ000535847, BJA/102 - INQ000535848, BJA/103 -

INQ000383557, BJA/104 - INQ000383550, BJA/94 - BJA/94 - INQ000048822]. See also [BJA/212 - INQ000535830] which details End to End process map for technical, clinical validation and commercial approvals. Note that the AHSN Network seconded some individuals into Covid Testing hence the slide template used:



130. In the training we set out the role of Commercial as follows:

3.0 Commercials role in Test & Trace?

- To optimise commercial arrangements with suppliers to the Test & Trace programme and to maintain ongoing strategic relationships:
  - Deliver vfm for the taxpayer
  - Advise on routes to market and implement commercial strategies that are legally compliant
  - Develop robust contracts that deliver fit for purpose solutions for HMG
  - Identify commercial risks and communicate to stakeholders to facilitate informed decision making. Support the development and implementation of mitigating actions
  - Contribute to the development of key documentation to facilitate effective decision making and demonstrate due diligence e.g. ministerial submissions, business cases etc.
  - Provide an audit trail for decision making that is robust enough to withstand scrutiny
  - Foster strategic relationships with suppliers to support successful contract delivery, to allow for effective performance management and act as an escalation point for operations

3.0 Commercials role in Test & Trace?

Listed here are some of the activities Commercial have been delivering in Test & Trace… While the work has been varied, interesting and rewarding we have often driven decision where normally Policy or Operations would hold responsibility and this leaves us exposed as a function…

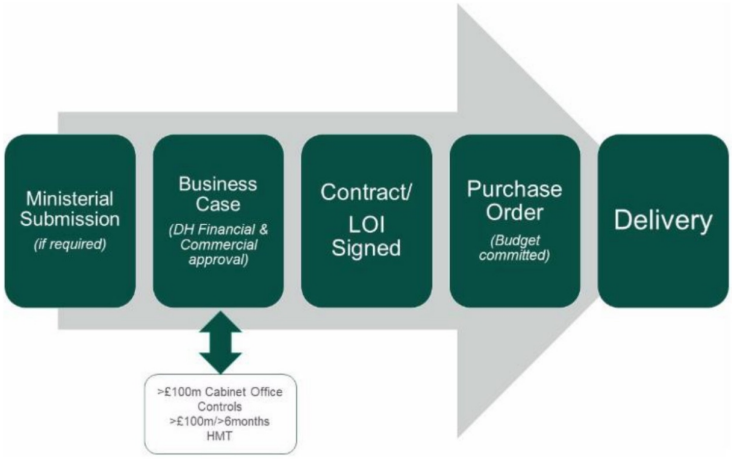
Commercial Area	Activity
Category Involvement	Lab capacity & Consumables
	Point of Care
	Antibody
	Logistics
	New Testing Technologies
	Digital
Early Engagement	Shaping requirements
	Developing tender documents
	Attendance at meetings/ boards
Commercial Delivery	Supplier negotiation
	Contract & Document Drafting
	Approvals/ Business Cases (Ministerial Submissions, HMT, Cabinet Office Controls)
	PO's/Requisitions etc

Commercial Area	Activity
Contract Management	Implementation/Roll out
	Troubleshooting issues
	Termination
	Relationship Management
Commercial Processes & Other	Managing offers/triage process etc
	Innovation - Scoping new solutions (commercials, scale, identification of use case, validation, pilots)
	CANs/ Reg 84 etc
	Reporting
	Data & Forecasting
	FOIs/ press queries / PMQ's
	Procurement/ legal challenges
Function Design	Best Practice Commercial Structure
	Business process and tools

131. We also covered processes and approvals:

4.0 Processes & Approvals

In the simplest of terms, due to the value and importance of most of the contracts we are dealing with the following process would be followed (please note that the figures for Cabinet Office Controls etc. are still to be confirmed – currently £10m+



132. I also delivered a technology knowledge transfer session at Jacqui Rock's NHSTT Commercial All Hands on 4 November 2020 [see BJA/213 - INQ000561762, BJA/214 - INQ000535878, BJA/215 - INQ000535887]. The slides provide an overview of all the different technologies, and I explained the methodology in an accessible way. I was handing over to Corrine Laguarde so she introduced my session. Feedback was very positive on how helpful it was for the Commercial Team and Jacqui referenced it in the email she sent out to acknowledge my exit from NHSTT; *"Also returning to the Complex Transactions Teams is Bev Jandziol and I would like to give her a special mention. Bev was one of the very first on the ground in Commercial 9 months ago and what an impact she had made. We've all seen*

what incredible technical knowledge she has (remember that testing technology session at All Hands?)..."].

133. I was not a direct or indirect beneficiary of any contracts awarded by NTP or NHSTT.

134. There will be hundreds of documents confirming approvals held within my archived accounts. While I have referenced some examples within this statement, as mentioned elsewhere in this statement, prior to my departure from NHSTT a database was set up where all business justifications, submissions and associated approvals were saved. It is my recommendation that the Inquiry accesses that database to view the full portfolio of documentation and approvals.

M. ADVICE FROM OFFICIALS AND CONSULTANTS

135. The advisers were mainly testing/technical advisory groups, sometimes No. 10 SpAds, scientific advisors and academics. Sometimes we would utilise consultants/contractors within the team to deliver the work.

136. Deloitte representatives joined a meeting with Kirsten MacLeod, other OLS colleagues and I on 19 March 2020, following which Deloitte became installed as the operational enabler/implementer of third-party Testing capability (essentially lighthouse labs). I do not know the route by which Deloitte took on this position - it was not my decision although I reference an email thread which indicates that Minister Lord Bethell had requested Deloitte "bring in a 10-20 person PMO function to run this" [BJA/73 - INQ000535744]. During the meeting, Deloitte said they could 'deploy circa. 200 staff the very next day.' Kirsten MacLeod responded by saying very clearly that she would decide on the level of resources to be deployed and instruct accordingly. During that meeting she did not agree to the offer of resources to be deployed at this scale. Unfortunately, Kristen MacLeod was then ill for several days (I cannot recall the exact duration) but during that period from 20th March and the following days, the number of Deloitte personnel on site (DHSC) grew significantly. I would estimate that there were circa. 200 people from Deloitte by the end of the first two weeks. I think at peak levels there were around 1000 individuals from Deloitte deployed in Testing Operations.

137. While there were some brilliant personnel deployed by Deloitte and they delivered some excellent work I considered at the time (and still do consider) that some Deloitte personnel displayed undermining behaviour to NHSTT. For example:

a. There was a daily (7 days a week) 9am testing stand-up for Pillar 2 attended by Tim Byford who represented Commercial. There would be around 30 people in the room, generally 3 or 4 Civil Servants, one military lead and the remainder were from Deloitte. While external Consultancy resources were absolutely necessary, I believe the power imbalance in the room was not appropriate. Initially a Commercial update was not even included as a standing item (despite the c99% supplier delivery).

b. There was strong resistance from some Deloitte staff to share information, take direction and follow instructions. For example, Deloitte had instructed a supplier to draft a business justification. When one of my team explained this was not appropriate and that the individual from Deloitte as the workstream lead should author the business case the individual was dismissive and said *"...I honestly don't have time for it today nor do the team – there's no reason they [the supplier] can't fill it in."* [BJA/216 - INQ000535861]. When I escalated this to one of the senior partners at Deloitte I did not receive a response [BJA/217 - INQ000535860]. A notable exception was the Deloitte Commercial team (led by the partner Nick Prior) who immediately switched to a supporting and consultative position under Tim Byford.

c. Deloitte instructed individuals who were expanding the use of direct LAMP in University hospital settings to ignore the direction provided by scientific advisors appointed by Professor Dame Sue Hill to oversee implementation. When this was brought to my attention, I escalated to Professor Dame Sue Hill and other key stakeholders and a meeting was scheduled with representatives of Deloitte. The purpose was to ensure alignment on the validation of LAMP and that those working on this should follow the instruction and guidance provided either directly by Professor Dame Sue Hill or via scientific advisors she had appointed as part of her wider team. Professor Dame Sue Hill is very collaborative and kind in how she engages with people, and it was disappointing that she had to intervene in this way [BJA/218 - INQ000535862].

d. Mass Testing was divided into missions by technology and use case. Unfortunately, this seemed to drive unhelpful competitiveness between the missions and at times a dismissive approach to alternative solutions (this issue was not solely related to Deloitte). During the Mass Testing Day

meeting I expressed my disappointment at the lack of progress made in validation of LAMP in laboratories particularly as it had previously been successfully implemented in a mobile van and on an A&E ward; getting it to work in a laboratory should not have been an issue (it was led by individuals in Deloitte who frequently ignored scientific advice as referenced above). Alex Cooper was equally frustrated and sent the following email after the meeting [BJA/219 - INQ000535874]:

All,

It was clear this morning that there remains confusion over the long-term goal for LAMP. This is disappointing as LAMP advocates have been consistent and this was the technology that first catalysed the concept of mass testing in the UK (see below for an example).

We are now arguably 3-4 weeks behind where we could be and this note resets our current approach and should provide unequivocal guidance for teams.

- **Leadership.** The incoming Chief Nurse, Eamonn Sullivan (cc'd), has very kindly agreed to lead the LAMP effort on an interim basis.
- **Desired end state.** Direct LAMP employed in multiple locations outside of a lab setting and integrated into NHS/T&T data systems.
- **Target use cases.** As per brief this morning.
- **Immediate priorities.** How could Direct LAMP be used to provide regular asymptomatic testing for NHS employees in areas of high COVID-19 prevalence – N England and equivalent prevalence areas of other nations. CMO has reportedly asked Dido for this testing to start asap. @Pickard, Alexandra leads for this.
- **Engagement.** Vital that our efforts complement and are supported by Keith Godfrey and other LAMP champions including James Phillips.
- **Brief.** We will confirm the brief of the LAMP plan shortly.

Yours,

Alex

e. This behaviour was not universal throughout and we worked with some excellent individuals from Deloitte. Clearly the Testing Operation could not have been delivered without Deloitte as there was a lack of Civil Servants and capability available to do so, but there did not appear to have been a setting of boundaries or operational rules and this led to at times, a very difficult position for myself and the rest of the Commercial team as well as other stakeholder groups.

138. While I have used examples specific to Deloitte, it is reflective of the size of their workforce deployed within NHSTT and the issue went beyond Deloitte. There was a significant imbalance between Civil Servants and Consultants/external secondees across all facets of the Testing programme. We benefitted significantly from external expertise, and they provided mostly highly experienced resources that were very much needed. However, often Consultants/Contractors (individuals as well as those deployed by Consultancies) and other externals were put in decision-making roles where they had too much autonomy for which they were unable to take accountability. There was a lack of understanding of the risks and implications of some of the decisions and actions they were taking. They were also often in post for a very short time. As referenced earlier in this statement, externals were seconded

on very short-term contracts. From a commercial perspective very few of them understood the transparency and legislative requirements associated with public sector procurement which exposed us to increased risk.

139. My Team came under significant pressure from multiple parties to agree contracts. I have already provided some examples within this statement of the challenges we faced when my team and I were trying to be diligent in ensuring value for money for solutions that were fit for purpose; there was a lack of understanding of our role with many seeing Commercial as 'rubber stampers.' I include an example response from myself below to a stakeholder who did not understand why we needed access to some critical technical information:

> We are all working under extreme pressure and managing multiple stakeholder relationships but we can only do our job effectively if you are open and transparent with us and share information that is critical to bringing the contract to a successful conclusion.
>
> Only a few weeks ago you were insisting we had to turn this contract around in 24 hours yet here we find ourselves in a position unable to sign as the solution does not have the necessary approvals for a blood collection technique that is not even endorsed by the OEM's. This poses a significant risk. Audrey has worked hard to build a robust contract and service specification as quickly as possible and to secure the necessary approvals from Cabinet Office Controls and HMT yet we are not in a position to sign the contract due to this critical milestone not being achieved.
>
> Commercial due diligence encompasses far more than cost, we also have a duty of care to ensure we implement a workable solution so understanding the validation process is something we need to have sight of.
>
> We can refrain from further involvement on the validation side if you are managing this but we will not endorse signing of the contract until this has been resolved and we will need to document and share with the relevant decision makers that this is our position prior to signature.

140. There was also at times a cavalier attitude to the value of money, with one stakeholder (who was an external non-civil servant secondee) rebuking one of my team for trying to negotiate terms on a £65m contract stating, "why are you bothering, £65m is like a drop in the ocean." On occasion that same individual (and others) would allow the exclusion of my team from meetings with suppliers where commercial terms were being discussed.

141. The appointment of consultants was done by selection from an existing CCS framework - MCF3. I cannot recall the exact process, but my recollection is that Bryony Gale ran a 'request for proposal' process supported by Chris Ryan who helped evaluate the responses. The reality is everyone on the framework was working on Covid, so we took on those who submitted a proposal who had availability (some declined as they did not have anyone available, for example Proxima).

142. I do not know the total expenditure on public sector officials for NHSTT.

143. Regarding the role of external consultants and contracts with respect to making decisions on procurement, they were embedded in the commercial team and where possible they would work alongside civil servants. They got involved in all aspects of delivering the procurements under the instruction of myself and other civil

servants. From August onwards we developed an induction training pack as referenced earlier. As we expanded the Commercial Team under Jacqui Rock's direction from late August onwards, most resources working in Commercial were from Efficio and 4C Consulting with a smaller proportion provided by EY. There was also an increase in recruitment of commercial expertise brought in on fixed term contracts. As they were procurement specialists, we found that they were able to assimilate into the Commercial team very quickly and they delivered some brilliant work.

144. Regarding key appointments made by me and/or recommended by me to the UK Government as part of being the Commercial Lead, in June 2020 I brought in Steve Malik as a contractor (paid on a day rate); I refer to my email enclosing his CV, sent on 1 June 2020 [BJA/220 - INQ000535797 and BJA/221 - INQ000535796]. I also provided a business justification form; see [BJA/222 - INQ000535798]. Steve Malik had worked as an intern in the consultancy I previously worked at Procure4. He had just graduated with a first-class degree and did not have a job as his offer from Procure4 fell through due to the pandemic. I knew he had strong skills in data and analysis as well as an understanding of procurement so I brought him in to help set up the contract register and get on top of our public procurement transparency notices which we were non-compliant with as we were meant to publish within 30 days of contract award but we were delivering so many contracts that we did not have the resources to keep on top of these obligations. He was contracted via PSR in a "Commercial Officer" role starting 15th June 2020. He transferred to a fixed term appointment in December 2020 as a Grade 7 Data & Reporting Team Lead. This role was categorised as 'enduring' and approved by the Test & Trace Vacancy Triage Board in October 2020 with Sarah Ellis as line manager and Jacqui Rock as programme lead. I was not involved in this change in appointment and he no longer reported to me. In May 2021 he was appointed to an updated role, Grade 6 Head of Commercial Data and Reporting appointed through fair and open competition – this role was advertised on Civil Service Jobs in April 2021. He was interviewed by Sarah Ellis (Commercial Operations Director) and Jacqui Lindsley (Commercial Operations Deputy Director). I was not involved in this appointment.

145. I also recommended other individuals who I had previously worked with and two were successful in obtaining fixed term contracts - Chris Ryan (ex-colleague at Procure4) and Nicola Thomson (ex-colleague at e-Three). Neither reported to me and I did not interview them.

146. Regarding the relevant areas of skills, expertise and/or expertise of appointees, initially all government departments surged lots of staff into Covid (PPE, Testing etc.). In Testing we had struggled to secure the right level of commercial civil servants which was escalated to Janette Gibbs, interim CTT Director Gareth Rys Williams, Government Chief Commercial Officer and Steve Oldfield, Chief Commercial Officer and Director General of Commercial Life Sciences at DHSC on several occasions. The situation worsened as after a few months home departments were starting to request the return of staff. We had no other option but to go external to increase our commercial resources as the volume of work we had to deliver was not sustainable for a team of circa. 25-30 individuals.

147. Regarding the appointment process, I produced a business justification for Steve Malik and for the other two I recommended as potential recruits; they submitted CVs and were interviewed by others. These three are the only individuals recruited in which I had some involvement. I had referred others, but they were either unsuccessful in being recruited or had decided they did not want to work in NHSTT. I do not know how many were recruited by others in NHSTT.

N. OVERALL VALUE OF THE CONTRACTS AWARDED

148. Not initially but as time went one most procurements were under Regulation 32 so were not competed for. If it was possible we would try to negotiate where possible and challenge costs, but it is important to recognise that we were operating in markets where supply was limited and global demand exceptionally high. However, despite this we made significant savings including cost avoidance; £929m savings and £520m cost avoidance. We also introduced an adapted governance structure for approvals as soon as we could.

149. For example, it was critical for us to secure a certain volume of LFTs so they could be deployed at pace amid rising infection rates. Most of the LFTs evaluated had failed the technical evaluation carried out at Porton Down. Although I had no personal involvement with Innova (it was dealt with by someone else in Commercial), Innova was one of the tests that had passed the evaluation stages whereby there was enough confidence in progressing to contract and Abbott Panbio and Tanner Pharma were two other tests that had passed the evaluation stages. Clauses were included in the contracts to allow for termination if the test failed to obtain any outstanding validation or accreditation requirements. This led to contracts with Abbott Panvio, Tanner Pharma and Innova. Innova was also the only test approved for self-use by the MHRA.

O. STEPS TAKEN TO ELIMINATE FRAUD AND THE PREVALENCE OF FRAUD

150. Due to the technical nature of PCR and LFD tests that we were procuring and the validation process, Commercial did not consider it was likely that suspicious approaches or offers would be awarded contracts. The Commercial Team requested information from prospective suppliers to validate an offered solution. Where offers were received that, on the face of it, seemed like an exciting technology, it was easily identified if the offer was an "entrepreneurial idea" or concept with no substance and the offer was quickly discounted. While I did not have direct engagement - as I understand it DHSC's Anti-Fraud Unit carried out due diligence. I am not aware of any suspected fraud that occurred. Most suppliers we dealt with were known e.g. were on frameworks or had contracts with academic and health institutions.

151. I do not consider that I am qualified to comment on the effectiveness of the processes and procedures to eliminate fraud during the pandemic. It was not considered a significant risk by me.

P. CONFLICTS OF INTEREST

152. All GCF commercial personnel must sign up to a Conflict-of-Interest (CoI) statement annually. I did not oversee the wider CoI process for those deployed who were not civil servants. In terms of triaging inbound referrals from Ministers, MPs and others we would tag them so we could feed back outcomes, but we did not expedite inbounds or treat them differently to other offers being triaged; it did not change the question of priority. It helped that technical compatibility was critical, so we were able to discount offers that were unsuitable. This is not to say that sometimes wider topics were considered in decision-making for example in relation to the procurement of BGI kits via Oxford Nanopore [BJA/86 - INQ000561737]. There were sensitivities relating to Propriety and Ethics as well as ensuring relations with countries were handled appropriately.

Q. CONTRACTUAL PROVISIONS AND PERFORMANCE BY SUPPLIERS AND MANUFACTURERS

153. Where possible we used standard DHSC Terms and Conditions customising only when absolutely necessary. Sometimes we would use PHE Microbiology Framework terms and conditions if more suitable. We engaged with scientific advisors to customise terms for new testing tech e.g. the LFTs introducing batch clause testing and the opportunity to exit the contract if validation was not satisfactory.

154. Mostly the process was effective but the reason there were so many follow up disputes was because we committed to volumes that were ultimately not needed (for example refer to email thread where the business case states a target capacity of up to 4m tests per day – [BJA/223 - INQ000535877]), as a lot of the decisions on testing technology and capacity were made prior to the existence of working LFTs and the vaccine e.g. ePCR, LamPORE and LAMP. For example, the volume for the LamPORE contract was doubled from the original intended value. Decisions were often driven by No. 10.

R. COMPLIANCE WITH PUBLIC LAW PROCUREMENT PRINCIPLES AND REGULATIONS

155. During the first 6-9 months, most contracts were delivered through Regulation 32 direct awards, due to urgent need, limited supplies, high demand, uncertainty, lack of suitable compliant commercial and technical specificity. We did not have the time, or there was no competitive market, to enable competitions and there was insufficient framework coverage. This is why we were so heavily reliant on Regulation 32. At points we were buying from everyone who could supply a technically compliant solution. I authorised the process to tender for a replacement for the Microbiology framework working with Nilesh Pattani of PHE so we could move towards being less reliant on Regulation 32. Despite not running competitions we engaged broadly with the supply base. As mentioned earlier in the statement we used existing frameworks to engage with suppliers, participated in industry attended webinars and used wider networks to identify potential suppliers. I engaged with the Rockefeller Foundation to obtain their database of global suppliers, and we initiated a triage process where we would call suppliers and assess suitability.

S. OPERATION AND EFFECTIVENESS OF REGULATORY REGIMES

156. I did not bring about any changes to regulatory regimes. Whilst we would try to standardise specifications for consumables where we could, for example, swabs, technical compatibility was critical and not something we could compromise (because of CE and MHRA accreditation). We did work with MHRA to obtain exceptional use authorisation from MHRA where possible for LFTs to increase the options for rolling these products out for public use. This process enables medical devices to be placed on the UK market in limited circumstances when they do not have a CE or UKCA marking.

T. DECISIONS AS TO WHAT TO BUY AT WHAT COST

157. We worked with the supplies director/SROs and policy colleagues as well as No. 10. Decisions would be made on quantities to buy and what to buy (including technical specifications). We also engaged with scientific advisors and the VTAG (Viral Testing Advisory Group which became NTAG. Commercial's role was to negotiate and put contracts in place.

158. This process was not always coherent and joined up. Instructions came from too many different sources, and when appropriate my team and I would actively challenge decision-making which sometimes led to a change in direction. We tried to deliver supply/demand planning for the NHS supported by Deloitte as referenced earlier in this statement. This was better managed among the lighthouse labs. But once we started moving towards targeting 800k and 1m tests per day and the commitment to the endpoint PCR 'megalabs' and other testing solutions it became extremely difficult..

159. It is my view that no one received preferential treatment based on their status as a political donor or other connections to those within government and it did not influence any commercial decisions in which my team or I were involved. However, I cannot categorically say that connections did not ease access to the system for procurement given the referrals we received from MPs, Ministers and members of the House of Lords. For example, the case of contracts with Randox has been well documented via the National Audit Office investigation in which I participated (Investigation into the government's contracts with Randox Laboratories Ltd - NAO report [BJA/224 - INQ000535890]). Whether with Randox or other suppliers deemed to have connections to those within government, I can confidently say that neither myself nor members of my team were influenced by such connections when it came to commercial decision-making.

U. SUITABILITY AND RESILIENCE OF SUPPLY CHAINS

160. Regarding the suitability and resilience of supply chains for LFTs and PCR testing equipment immediately prior to the pandemic and with the benefit of my experience I now consider there was no resilience. We were too reliant on large international suppliers. The Life Sciences industry of SMEs had been neglected, there was over-reliance on closed PCR systems and it we were vulnerable to the USA's defence position when the USA administration passed legislation preventing the export of US manufactured Covid-19 related supplies.

161. Regarding the suitability and resilience of supply chains during the pandemic, we tried to improve resilience by diversifying testing technology and supplies. We also tried to automate and mechanise the lab-based testing including PCR and LAMP. However, when the organisation structure was aligned to testing technologies, the larger expanded teams became quite siloed and it drove a competitive approach that worked against collaboration. Rather than recognising the benefit of diversification and matching of solutions to use cases, teams started to see it was a competition between technology and would 'talk down' solutions to justify why funding or resources should be diverted to their specific technology workstream.

162. Regarding the suitability and resilience of supply chains following the pandemic, and how they could be improved in the future, I think it is probably now better, particularly with the merger of NHSTT and PHE to create UKHSA but I still think there is an over reliance on PCR and LFTs without fully capitalising on the alternative testing solutions we had invested in. There is no guarantee that LFTs would be suitable for a new viral pandemic and I am concerned that the dismantling of the infrastructure was delivered in a way that did not retain all the intellectual property and learnings to enable better preparedness and more efficient scale up if faced with a similar situation in the future. Despite having played a central role in the establishment of Covid-19 testing capacity and capability from its inception through to the end of 2020, I have never been consulted or included in any workshops on lessons learned. I was not consulted as part of the Boardman Inquiry although my colleague Tim Byford was engaged and therefore was able to provide Commercial input. I did draft a report for Gareth Rhys Williams in December 2021 at his request when a colleague I had worked with in UKHSA had expressed concerns about the approach to termination of the Testing automation programmes without due consideration to fully document the learnings and knowledge gained that could be useful for scaling up future capability if needed [BJA/225 - INQ000535889]. The paper was shared and then discussed in a meeting with key stakeholders within UKHSA which included UKHSA Commercial Director, Sarah Collins. Gareth Rhys Williams urged UKHSA to give due consideration to the recommendations.

V. CHANGES TO PROCUREMENT PROCESSES

163. The provisions of Regulation 32(2)(b) and 32(2)(c) of the Public Contract Regulations 2015 ("2015 Regulations") were the procedures most used during my time in NTP/NHSTT due to the need to procure under extreme urgency.

164. Where the relevant criteria are satisfied, the 2015 Regulations permit the direct award of contracts due to (a) the absence of competition or protection of exclusive rights, and (b) reasons of extreme urgency. Guidance on these provisions is contained in the Cabinet Office's *Procurement Policy Note 01/20: Responding to COVID-19*.

165. These provisions were critical to enable my team and I to deliver the necessary procurements to deliver the objectives set out by the NTP and latterly NHSTT. In the short term they were highly effective for use during the pandemic as they set out clear criteria for justification providing a framework for decision-making and a robust assessment of risk. We utilised GLD to provide advice across our procurement decisions so we could clearly present the risks to Ministers and other key stakeholders as required. They also supported us on contract drafting whenever there was a deviation from standard terms. However, as time progressed, the Regulation 32 provisions were over-relied on, and it became more challenging to justify their use e.g. while requirements were initially unforeseen, this was not justifiable as the pandemic progressed.

166. It is my opinion that we over-relied on the provisions of Regulation 32 for too long. While there continued to be situations when direct award was justifiable e.g. lack of competition for technical reasons and limited supply options this was not the case for all, particularly as time moved on and alternative solutions emerged. The main drivers for its prolonged use were:

    a. Inadequate commercial resources to run competitive processes. It is only from August 2020 onwards when a concerted effort was made to 'right-size' the commercial function.

    b. Stakeholders across NHSTT had become accustomed to the ability to contract with suppliers through direct award and were reluctant to accept an alternative route. For example, in one scenario when I made it clear that there was no justification for a direct award and recommended that we could run a light touch regime process in circa. 6 weeks I received significant resistance [BJA/87 - INQ000535854, BJA/88 - INQ000535853, BJA/89 - INQ000535855].

    c. Up until the end of 2020, most people operating within NHSTT including senior leadership were not civil servants and many had limited experience of working in the public sector so were lacking in understanding of the legislative and transparency requirements associated with public sector

procurement so did not understand the ramifications of non-compliance. I have included a reference example in the above paragraph where I pushed strongly to run a competitive process and was met with resistance, despite endorsement from Legal colleagues. This sort of resistance was a common occurrence. In that example, stakeholders wanted to give a direct contract to ScaleDX and Capita FERA. In an email sent by Emma Stanton to Jacqui Rock on 18 August 2020 she recorded the position of my Commercial team: "*Rather than proceed to direct award, Bev & team have strongly recommended that we would need to run a 5-week tender for this…".* Despite my recommendation and that of Legal, there was resistance by stakeholders: Jacqui Rock was approached in effect to see if she would give a different answer, the email continuing:"*On discussion with Barbara this evening, copied, it would seem as though there are other ways we could do this faster. …**Can I ask for your help in establishing a faster procurement route for an end-to-end testing solution that we could deploy in outbreak settings?)'*** Jacqui Rock in reply endorsed my view, commenting that "*The commercial team are proposing a 5 week competition no doubt because we have had a clear steer from CO that we should not carry out any more direct awards for professional services."* I reiterated my views and those of Legal, sending an email on 21 August 2020 timed at 15.34 "Readout from Legal / Commercial Meeting regarding Scale DX and Capita FERA" which included the assessment from Legal, which was that Legal (along with Commercial) believed that the '*risk with direct award would be very high'*. In my email sent on 31 August 2020 at 23.54 I again repeated my views as to these risks, stating in relation to Scale DX that "*Overview – too risky to consider contracting through Reg 32 direct award (based on risk and capability). Would need to put them through a rigorous competitive process where they would have to demonstrate their capability"* and in relation to Capita FERA "*Overview – While less risky than Scale DX in relation to their capability. Contracting with them under Reg 32 would be of high risk for similar reasons and it would be advisable to run a process whereby other potential competitors in the market are able to put proposals forward.".* Despite the stakeholders' attempt at resistance, they ultimately accepted the need for competition; I refer to Barbara Bradley's (of PA Consulting) email sent on 1 September 2020 at 19.28 which stated "*We are keen to take this discussion to the next level fairly quickly and have a conversation about how best to run a mini*

competition. Keen to do this with as much on the shoulder support from commercial (and legal) as we can possibly get so it's done cleanly and successfully". On 4 Septemper, in response to the proposal, I responded that *"We need to allocate some dedicated resource to this as to turn it around as quickly as possibly and to determine the requirements to take to tender it needs someone focused on it full time for that period as there is a lot of work involved….However, I think whichever route taken Scale DX would need to partner with another provider to be able to compete effectively with other providers. We will need someone with experience of running compliant procurement processes and I don't have a civil servant with capacity so its likely that I would need to assign one of the EY consultants we bring in".* This supplier disappeared as it did not really have a fit for purpose solution so there was no direct award or competition. However, it illustrates the fact that there was a lack of experience and understanding of the increasing risks of challenge. I did not ignore this issue but I did not always receive the support to push for change.

167. We were not resourced to comply with transparency requirements in the early days and weeks. The volume of work was such that we could not prioritise the timely publication of transparency notices and contract award reports over the action we needed to take to secure and contract the required supplies. I knew it was important to remedy this situation which is why I recruited resource (Steve Malik) as detailed earlier in this statement to help our team to try to clear the backlog of transparency notices. With hindsight, not publishing transparency notices generated suspicion from the press and led to an increased level of Freedom of Information (FoI) requests and Parliamentary Questions (PQs). We may have been able to mitigate some of these issues if we had made a public statement that we were pausing the publication of notices but committed to a date for publication that was deliverable which may have reduced the volume of FoIs and PQs and the additional workload it generated.

168. Current PCR 2015 regulation did not provide the flexibility within existing frameworks that would have significantly improved our ability to procure compliantly and rely less on direct awards. As explained within this statement, the inability to extend the spend envelope of existing frameworks meant they were essentially unusable.

169. Procurement process did not significantly change during the pandemic except for a gradual reduction in the utilisation of direct awards and the shift to more standard competitive procedures once the replacement Microbiology framework went live and

Jacqui Rock had implemented a more adequately resourced NHSTT Commercial operating model in early September 2020. However, Governance did improve in that for the first few weeks we did not follow the usual Governance processes e.g. Cabinet Office Controls approvals. Decisions were approved and made on an ad hoc basis e.g. direct engagement with HMT via DHSC Finance and the DHSC accounting officer as required to approve financial spend envelopes and we did not do the usual contract due diligence because of the urgent need to secure our requirements. However, in early April Cabinet Office Controls became more involved and stood up an amended approvals process to ensure they could prioritise the review and assessment of critical spending decisions and assess the suitability of the commercial approach. Initially our engagement with Cabinet Office Controls and HMT was challenging as there was a lack of understanding relating to the constraints under which we were operating e.g. they would try to impose conditions that would be reasonable in a business-as-usual environment but were not feasible in the context in which we were working. However, as they deepened their understanding of the situation, Cabinet Office Controls engagement was welcomed by the commercial team as it helped us improve rigour across our contracting process and provided us with additional leverage in challenging decisions made by policy holders. I understand that ultimately spend controls on Test and Trace were removed in October 2020, but by then I was in the process of transitioning away from the commercial role, as set out above.

170. Forthcoming procurement reform will help avoid some of these issues documented here. One notable change is the ability to create frameworks that are more flexible and can be reopened during the life of the framework. If this had been available at the time it would have been significantly beneficial.

171. While Procurement Reform (see GCF, *Transforming Public Procurement*) will undoubtedly deliver benefits to process in an emergency, it includes incremental transparency requirements which will increase workload so without adequate resources, we would still end up in a position of non-compliance.

172. I want to reiterate that the processes themselves were not the primary issue; even if there had been valid frameworks we could have used or if we had more resources to deliver the procurements, I do not think it would have changed the outcome as there was no competition to be had because supply was so limited amidst global demand. For these reasons we essentially contracted with everyone in the market who could supply technically compatible solutions and service providers who had

the capability to stand up the infrastructure required to deliver the testing capacity required.

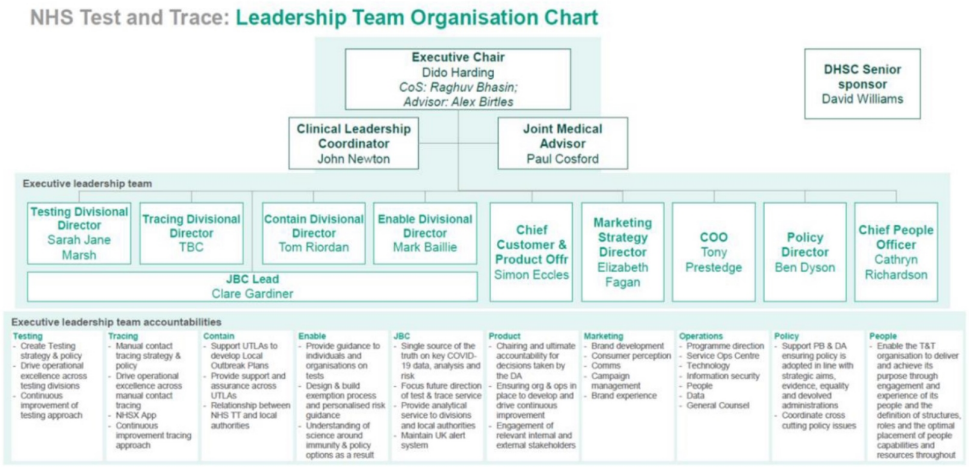
W. LESSONS LEARNED

173. Efficient, effective successful organisations recognise the importance of procurement as a strategic function that adds value far beyond that of a transactional procurement process. At the beginning of my career I worked in food manufacturing and the Chief Procurement Officer sat on the Executive Board. Procurement was seen as a function that delivered value for money while also increasing the value of the product through innovation driven by strong supplier partnerships. Less successful organisations view Procurement as a transactional compliancy process that has no strategic value. Under the direction of Gareth Rhys Williams, the GCF underwent transformation to establish its capability as a high functioning strategic function with the aim of delivering value for money while optimising supplier relationships and terms to deliver contracts that can successfully deliver while mitigating exposure to operational, financial and reputational risk.

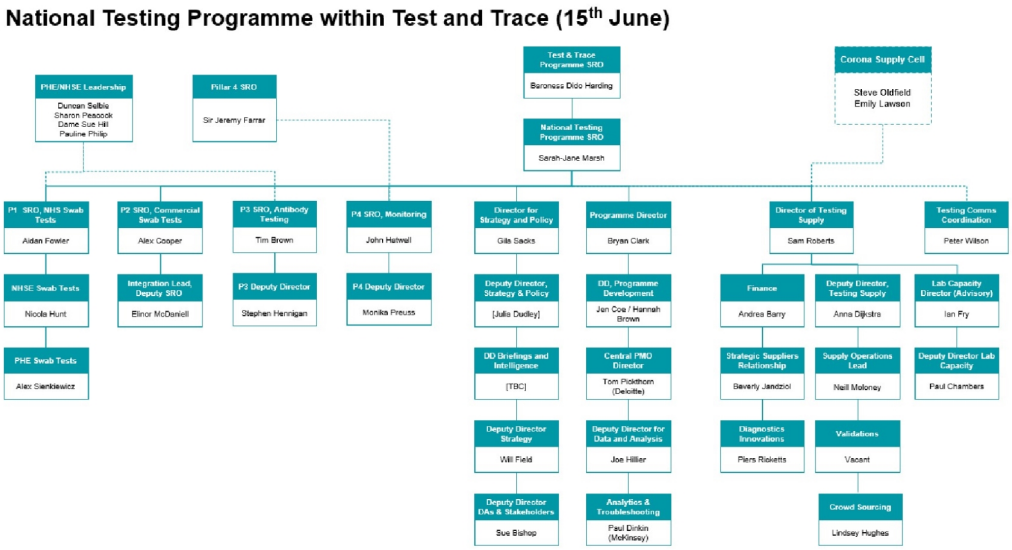
174. My reflections in this Lessons Learned section are based on my experience working in NTP/NHSTT during 2020 and therefore do not relate to procurement practice within NHSTT and UKHSA beyond this point. There were many positive examples of excellent collaboration working across NTP/NHSTT and despite the challenging circumstances and exhausting workload, it was also a uniquely incredible experience. I learned a lot and I was humbled by the determination, hard work and commitment of so many I worked with. However, for Commercial delivering procurements, it was also very challenging as the heightened stress of operating in an emergency reinforced some of the outdated views of Commercial's role being one that is transactional. As I have referenced in examples throughout this statement, we were at times not consulted early enough yet were expected to create multi-million-pound contracts upon request within unreasonable timescales. To quote another example, Pamela Doyle and I joined a Lab Capacity Board where *"we were taken through their view of the commercial progress. Both Bev and I explained the issue where the programme team are going off to find labs and then just expecting us to place orders."*

175. HMG is generally hierarchical in nature which means representation at the right level of seniority is critical. During the early weeks of NTP there was strong camaraderie and team spirit and the entrepreneurial way in which we worked removed the barriers attributed to inflexible hierarchical structures. This approach is not sustainable over

the longer term, but I think the initial implementation of the NHSTT organisational structure missed an opportunity to place Commercial in a position that would establish its criticality in having a strategic role to play in the responsible delivery of high-risk procurements that ran into billions of pounds in value. Despite the criticality of supplies and procurement, there was no commercial representation among CEO Dido Harding's senior leadership team (SLT). See org chart [BJA/42 - INQ000535814]:



176. Commercial or Supplies are not referenced among team accountabilities. I have included below the org chart within the Testing Divisional Director, Sarah Jane Marsh's remit:



177. This structure did not remain for long as Samantha Roberts departed soon after, as did others. To Dido Harding's credit she soon recognised the need to significantly

increase commercial resources under the leadership of a Chief Commercial Officer which is when Jacqui Rock was recruited to post. In practice I had sufficient access to Dido and other members of her leadership team when needed, so the structure was not as hierarchical and arm's length as it first appeared and was flexible enough to allow for agility and the need to work at pace.

178. It is not unusual for Commercial to face resistance when challenging buying decisions, but it was heightened during the pandemic. I am fortunate to have a high level of resilience as did most of my team, but we should not have had to rely on these skills alone to effectively do our jobs, when what was needed was a strong mandate to make informed decisions and facilitate challenge when needed. My recommendation is that the Commercial lead needs (formal and acknowledged, rather than assumed) Director level status and potentially more than one when responsible for a portfolio of this size and complexity.

179. One of the benefits of CTT being deployed was that we could be onboarded immediately, had a collective broad range of experience and capability (most of us had both public and private sector experience) and were used to dealing with complex commercial challenges and working with people we had never previously worked with. I also think it helped in having the confidence to challenge as we were not in the regular reporting line of the department in which we were operating. However, we were not sufficient in number to sustainably deliver what was needed. We should have only ever been a temporary solution for ideally three months and no more than six months; utilised as a start-up function while efforts are made in parallel to stand up a more scalable commercial organisation structure. We would have also benefitted from the inclusion of a broader range of skill sets and grades e.g. administrative, PMO, data and reporting support, etc. I would recommend a model similar to the agility model utilised in FCDO whereby 20% of the workforce is signed up as volunteers to support crisis response and this is across all directorates and disciplines. If required they can be redeployed at short notice to support a crisis. We could operate a similar list across GCF and ideally other disciplines that would essentially be a 'call-off' list drawn from across HMG covering the range of skills and expertise needed to stand up a function at pace (Commercial, Legal, Finance, Operations etc.). This could be augmented by consultants but would help in ensuring the right balance between civil servants and externals. FCDO also operates a robust shift pattern and a gold, silver, bronze command structure which we would have benefitted from in NTP/NHSTT. I did not have a single day off for the first 50 days and it was not unusual for me to work 16-hour days and sometimes 18 hours which

was not good for my wellbeing or sustainable effectiveness. This working practice was not unique to me.

180. Similar to the ability to rapidly deploy resources we would have benefitted from a readily available toolkit which included templates, processes and governance frameworks that are suitably adapted for a crisis to minimise bureaucracy while ensuring an appropriate level of due diligence and rigour over decision-making and systems for capturing the audit trail of decision making. Those of us from CTT were on a different operating system to DHSC (we were on Gmail and Google Chat, while they used MS Outlook and Teams). Even worse is that we had some contractors operating on their own personal computers and email accounts although this improved over time. However, all Consultants utilised their own technology and company accounts which again led to a significant loss in the ability to capture and retain information for audit trail purposes. I think the ability for departments to be able to respond in a crisis should be tested as part of standard business continuity procedures and preparedness should be regularly and rigorously assessed.

181. While I understand the reasons behind the decision to reject the request for delegated authority to CTT for signing contracts; in hindsight I think it was unfair for individuals to be signatories on contracts for which they had not had input or oversight. While we would provide a contract overview to allow for some insight prior to signing, sometimes they were far removed from the work so had to essentially trust that we had done our job effectively. As referenced earlier, Ed James had raised the point that there was no value in him signing the contracts my team and I were putting in place. Unfortunately, it had a personal impact because as signatory to many of the early contracts, he ended up featuring in a Private Eye publication despite him not being involved in the contracts he was being attached to in the article. On this basis, myself and others probably should have been granted delegated authority. However, this needs to be coordinated from the centre within GCF with clear guidelines on the criteria that need to be satisfied to justify the need for transfer of delegated authority.

182. It is important to remember that good procurements are not only reliant on skills, expertise and process but a diverse and sustainable supply market. Prior to the onset of the pandemic, PHE and NHS had become too reliant on large global suppliers and had failed to nurture relationships and develop the wider market, particularly the UK life sciences market that included small businesses. This is not uncommon across UK Government in other market sectors. Many of these

organisations were faced with too many barriers to access opportunities so were an untested market. However, as we built relationships with the wider market, they were often very agile and responsive to our requests which had a positive impact on our ability to increase capacity. We made a concerted effort to diversify the market as referenced throughout this statement. There is a significant focus within procurement reform in relation to the removal of barriers to small businesses, that coupled with more flexible frameworks and routes to market should assist in diversification of the Life Sciences supply base. It is my understanding that UKHSA has put a greater emphasis on supplier market development.

183. Dedicated contract management resources to effectively manage our Consultancy Partners is critical. This would have helped in providing clarity on the scope and objectives of their work to ensure they were being used to maximum effect, allowed for quality assurance of the work being delivered and the proportionate allocation of the right skill sets and resources. The number of Consultancy resources deployed grew unchecked because there was no oversight, and they were not accountable to anyone. Towards the end of her engagement in NHSTT, Pam Doyle engaged Gareth Clark from CCS to investigate the work delivered by Consultancies against the cost of claims made which involved a significant amount of work and effort.

X. STATEMENT OF TRUTH

184. 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**

Name: Beverley Jandziol

Dated: 31 January 2024