Witness Name: Sir Christopher Stephen Wormald
Statement No.: 14
Exhibits: CW14/1-180
Dated: 5 February 2025

UK COVID-19 INQUIRY

MODULE 5

FOURTEENTH WITNESS STATEMENT OF SIR CHRISTOPHER STEPHEN WORMALD

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1. I, Christopher Stephen Wormald, former Permanent Secretary of the Department of Health and Social Care, and now Cabinet Secretary, will say as follows:

INTRODUCTION

2. I make this statement in response to a request from the UK COVID-19 Public Inquiry dated 23 October made under Rule 9 of The Inquiry Rules 2006. I am asked to make a witness statement setting out my recollection of events connected to the procurement and distribution of key healthcare equipment and supplies including PPE, ventilators and oxygen, lateral flow tests ("LFTs") and Polymerase chain reaction ("PCR") tests covering the period 1 January 2020 to 28 June 2022.

3. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that the Department of Health and Social Care (the Department) continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material, relevant to this statement, will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be.

4. This statement has been read by the following individuals in final draft format to check only for factual accuracy:
   a. David Williams, Second Permanent Secretary at the Department of Health and Social Care between 5 March 2020 and 1 April 2021;

b. Jonathan Marron, Director General (DG) of Public Health and PPE between 18 March 2020 and 1 October 2021. Jonathan is currently DG for Primary Care and Prevention.

Background

5. I was the Permanent Secretary of the Department of Health and Social Care (DHSC) from May 2016 until 16th December 2024. I first joined the Civil Service in 1991 as a fast streamer at the (then) Department of Education and Science. I worked there until 2006, including in a role as principal private secretary to the Secretary of State for education and skills between 2001 - 2004. In 2006, I became Director General at the Department of Communities and Local Government (now Department for Housing, Communities and Local Government) where I was Director General of Local Government and Regeneration. In 2009, I became Head of the Economic and Domestic Affairs Secretariat at the Cabinet Office. With the formation of the coalition government in 2010, I took on an additional role as Head of the Deputy Prime Minister's Office until March 2012. I was also head of the Policy Profession between 2012 and 2016, which designs, develops and proposes appropriate courses of action to help meet key government priorities and ministerial objectives.

6. In March 2012, I was appointed as Permanent Secretary to the Department for Education. I held that role until May 2016, when I assumed the role of Permanent Secretary to the Department of Health and Social Care. I remained in post until 16 December 2024 when I became the Cabinet Secretary.

Role of Permanent Secretary

7. As I have set out previously in my statement to Module 2 of this Inquiry, (INQ000280628), the Permanent Secretary is the most senior civil servant in a department. The Permanent Secretary supports the government minister who is the head of the department, and they are accountable to the Prime Minister, Cabinet, Parliament, and the public for the department's performance.

8. As Permanent Secretary, I was responsible for:
   a. Ensuring ministers receive advice on strategy and objectives for the health and social care system. This will sometimes involve giving advice personally, but more typically the role is one of ensuring that people and systems are in place to ensure ministers get the advice they need from the wider Department.

b. Acting as the Chief Executive of the Department, setting standards and managing risk and assurance, as well as leading and managing the staff of DHSC (totalling 1,815 at the start of the pandemic) and ensuring that ministerial decisions are implemented (**CW14/1 - INQ000279946)**.

c. Acting as the Department's Accounting Officer (AO). In this capacity I was personally responsible and accountable to Parliament for the Department's use of public money and stewardship of public assets as set out in 'Managing Public Money' (**CW14/2 - INQ000279942**). I was also the Principal Accounting Officer of the Departmental Group, consisting of the Department and its sponsored non-Departmental and other Arms' Length Bodies (ALBs) as designated by order made under the Government Resources and Accounts Act 2000. The CEO of each of the ALBs acts as that ALB's Accounting Officer and is responsible to me as the Principal Accounting Officer.

9. In fulfilling these roles, I was supported by the other senior staff of the Department, including the Second Permanent Secretary, a role created in March 2020 in light of the scale of the task faced by the Department during the pandemic, and by the Chief Medical Officer (CMO) for England. I discuss the role of the Second Permanent Secretary in relation to procurement matters, in particular below.

10. In respect of the role of the CMO, Professor Sir Chris Whitty took office in October 2019, was the CMO throughout the pandemic period and remains so. The CMO is an integral part of the management structure of DHSC and a member of the Departmental Board and the Executive Committee (ExCo). In brief, the CMO acts as the UK Government's principal medical adviser, and the professional head of all directors of public health in local government and the medical profession in government. The CMO provides expert, independent advice on behalf of DHSC across government, including to ministers in DHSC and across government on both communicable and non-communicable diseases. The CMO is an independent position at permanent secretary level.

11. As the Permanent Secretary, my role did not involve making decisions about policy and very rarely would I personally create written advice or intervene on the substance of any advice provided. Such responsibilities are for ministers advised by policy makers and experts within the Department or from ALBs. Whilst I would be expected to have a good working knowledge of most areas of the Department's work, I would rarely be the expert on any specific area. My role centred on ensuring that advice was constructed properly,

assisting other officials in the development of their advice, and helping ministers come to decisions based on the advice provided to them. In practice, the majority of advice on policy areas given to ministers is developed by senior civil servants in the Department. After a particular approach is adopted, it became my role to ensure that ministerial decisions were implemented by the Department.

12. On major issues, I would have expected to be consulted upon submissions to ministers and contribute to the development and options set out for any decisions to be taken. This would normally be via discussion with the relevant director general or other senior staff. However, a distinction should be drawn between matters where I provided a view on the basis that it would be considered alongside other views, and those matters where I had a direct decision to take and expected my decision to be reflected in subsequent advice to ministers. The latter circumstance usually arose in respect of decisions I made as the Accounting Officer, or matters involving the Civil Service Code or the conduct of government business.

13. I would usually be copied in on all advice to ministers, regardless of whether I had been involved in its development. When this happens, my office would usually read the advice, summarise it, and all of the summaries would be put in my daily update. Having read the daily update, I would choose whether or not to intervene in any specific issue. This practice continued throughout the pandemic (for example, see the summary of submissions given on 19 February 2020 or 12 May 2020: **CW14/3 - INQ000279885; CW14/4 - INQ000279925**, respectively). Where policy developments involve clinical issues, a clinician within the Department would usually be consulted, or an advisor with clinical expertise. Such clinicians would usually be the CMO or a Deputy Chief Medical Officer (DCMO), but DHSC would also consult experts from arms' length bodies, such as NHS England (NHSE), Public Health England (PHE), or Departmental Expert Committees.

14. I would frequently attend ministerial meetings on key issues, for example where the subject of discussions relates to strategy, issues of controversy, or issues that are under debate with the Cabinet Office or No. 10. My role at these meetings would usually be to help ministers explore the options and identify the consequences and risks of particular actions. Frequently, I tried to act as a 'devil's advocate' to ensure all avenues are explored. I was rarely there to give direct advice, unless it touched on Accounting Officer matters or issues to do with the Civil Service Code, but I frequently gave opinions as a part of discussion. This process continued during COVID-19.

15. Over the course of the pandemic, I saw my role as:
    a. Managing and leading the Department so it was organised to deliver its pandemic functions, particularly so that it could deliver the Department's Battle Plan;
    b. Ensuring DHSC Ministers received the right advice at the right time;
    c. Troubleshooting where the system failed to work as it should;
    d. Representing the Department across government, including with officials at Cabinet Office and No 10, largely through attendance of departmental and cross-government meetings.

16. I was involved in a number of decisions within the scope of Module 5 taken by the Department in response to the pandemic, which I discuss below. In general, my involvement related to policy matters relevant to procurement and distribution rather than operational procurement or distribution decisions. That is to say that I was involved in developing the strategy and structural organisation (both within DHSC and between DHSC and other departments in some cases) for procurement and distribution, rather than individual procurement and distribution decisions at the level of day-to-day implementation, such as the decision to enter into individual contracts. I was very rarely involved in issues relating to individual contracts or procurements, and usually only in circumstances whereby another senior member of staff wished to escalate an issue to me.

Second Permanent Secretary

17. The role of Second Permanent Secretary in DHSC was created as part of the Department's response to the COVID-19 pandemic in the period January-March 2020.

18. The role was first held by David Williams who was formally appointed on 6 March 2020. David initially led on Finance (including COVID-19 Finance), Group Operations and 'business as usual'. Increasingly, as COVID-19 became the majority of the Department's work, David acted as my deputy across the board. From his appointment, David also became additional Accounting Officer on all departmental matters (**CW14/5 - INQ000273562**). David's role incorporated the Accounting Officer function in relation to procurements by the Department and the overall management of budgets. I was not involved in the setting up or delivery of policies. In respect of accountability and oversight, David applied the existing policies for such accountability which were devised before the pandemic. David Williams was appointed as Second Permanent Secretary on 6 March 2020. He was initially appointed to lead mainly on 'business as usual' matters

within the Department. It was agreed that he would have oversight of all financial matters and that he would lead on workstreams (ii) Supply and (iii) Testing, while I led the remaining strands: (i) NHS and social care resilience; (iv) Technology; (v) Social Distancing; (vi) Shielding; and (vii) Cross-Cutting.

19. We also agreed that David would become the Additional Accounting Officer for all COVID-19 specific procurement activity, including PPE, healthcare equipment (primarily ventilators), and testing and tracing. This meant David Williams was, in that capacity, responsible and accountable to Parliament for the use of public money and stewardship of assets in connection with procurement while he was Second Permanent Secretary until April 2021.

20. On procurement issues the Second Permanent Secretary delegated authority for all contracts of a value of £100m or less to the DHSC Directors of Finance Chris Young and Jon Fundrey. Chris Young was the Department's sole Director of Finance prior to the pandemic. Jon Fundrey, Chief Operating Officer at the Medicines and Healthcare products Regulatory Agency (MHRA) was brought in as a co-Director of Finance to assist during the pandemic.

21. This made the Second Permanent Secretary or Directors of Finance, as applicable, responsible for taking the decision on whether or not to enter into any contract relating to PPE, ventilators, or testing and tracing. While I was Principal AO for the Department, I did not take part in individual decisions about entering into contracts.

22. The division of responsibility between the Second Permanent Secretary and I reflected the need to maintain effective governance at a time the Department had significantly expanded its workload. The allocation of AO responsibility for procurement matters to David Williams reflected the fact David possessed significantly more experience than me in procurement and supply chains; I retained the role of Accounting Officer with David brought in as an Additional Accounting Officer (**CW14/5 - INQ000273562**). As well as having been Director General of Finance and Group Operations within the Department since 2016, David held the post of Director General of Finance at the Ministry of Defence (MoD) which he held from 2012.

23. David Williams and I would communicate frequently several times a day and would discuss matters as and when they arose; we communicated whether we were in the office or not. To give an example, he raised with me the criteria by which contracts

secured in Beijing and negotiated by the Embassy there should be implemented. We did not usually discuss individual contracts. Normally, we would discuss issues David wished to escalate. Occasionally, I would raise issues with him. This was generally because they had been raised with me by another government department: for example, after a Wednesday Morning Colleagues meeting (WMC). I would assist David, if required, by speaking with officials from other government departments (such as the Treasury or the Foreign Office) if my experience meant that I could quickly help to resolve any issues or problems. David Williams and I would also discuss general issues such as spending controls, and the level of risk which was acceptable given the pandemic (I discuss this further below).

24. Shona Dunn became Second Permanent Secretary in April 2021 until she left the Department on 3 June 2024. She was an Additional Accounting Officer on all departmental matters and acted as my deputy across the board. She had direct responsibility for all matters relating to Finance and Group Operations.

25. Tom Riordan became Second Permanent Secretary on 23 September 2024, and remains in this role.

Directors General (DGs)

26. Under the leadership of the Permanent Secretary and the Second Permanent Secretary, there were 5 Directors General (DGs) in the Department during the relevant period. I discuss the following Directors General who were responsible for workstreams within scope of Module 5.

27. Prior to the pandemic, Jonathan Marron was DG for Prevention, Community and Social Care beginning in June 2017. Mr Marron's involvement in PPE started on 18 March 2020 when he took on PPE related actions at the Reasonable Worst Case Scenario (RWCS) Oversight Board. In the following week he became DHSC DG Lead for PPE. This was formalised on 27 April 2020 when he became DG for PPE and Prevention, and his previous responsibilities were reassigned to other DGs in the department. Mr Marron was of course involved in matters of significant relevance to this module, and I understand will be providing his own statement. Mr Marron was then appointed as DG for Office of Health Improvement and Disparities (OHID) in October 2021, and after which he was appointed DG for Primary Care and Prevention which he remains as at the time of writing this statement.

28. Clara Swinson was DG for Global and Public Health from 2016 to 2018, and from 2018 to September 2024 was DG for Global Health and Health Protection. In this role she was responsible for leading teams handling emergency preparedness and health protection, international policy and EU Exit. Clara Swinson was the DG level Senior Responsible Officer (SRO) for the COVID-19 Battle Plan in the Department, which I discuss further below. In 2020 and throughout the relevant period, Ms Swinson's responsibility expanded to include COVID-19-specific directorates on social distancing strategy, the COVID-19 programme (and Battle Plan), COVID-19 vaccines deployment and the Therapeutics and Antivirals Taskforces.

29. David Williams, as I have already mentioned above, was the DG for Finance and the NHS Group from March 2015 to April 2021. He was responsible for ensuring financial accountability of the health and social care system, with his responsibilities adjusted to include Group Operations from July 2016. Andy Brittain succeeded David as DG for Finance in April 2021.

30. Lee McDonough was the DG for Acute Care and Workforce from November 2016 to November 2020. She was responsible for policies on acute care and quality, NHS workforce, and NHS efficiency and productivity. Ms McDonough then became DG for the NHS Policy and Performance Group from 2020 until June 2021, responsible for policies on provider performance, care quality, patient safety and investigations, NHS workforce mental health and disabilities, and primary and community health care. She was also the senior departmental sponsor for NHSE and NHSI. I provided oversight of the Group's work until her successor started in post.

31. Matthew Style is the current DG for NHS Policy and Performance Group, who took up this post in November 2021. In addition to the above responsibilities carried out by his predecessor, Mr Style took on responsibility for medicines and medical technology policy in October 2022. Mr Style was previously the Deputy Chief Financial Officer for NHSE.

Chief Commercial Officer

32. Steve Oldfield, DG and Chief Commercial Officer, was appointed in October 2017. His responsibilities included Medicines and Medical Technology Policy, commercial strategy, leading on the development of commercial capability and the sharing of commercial best practice across the wider health family, as well as the strategy and engagement with the life sciences sector. In his role as DG for Commercial and Life Sciences, Steve was responsible for continuity of supply. After Steve left the Department in October 2022 the

role of Chief Commercial Officer at Director General level was not replaced. Melinda Johnson was appointed as Commercial Director in July 2017 and left the role in August 2023.

Stockpiling, procurement and distribution of key healthcare equipment and supplies

DHSC and cross-government response to COVID-19

33. Before the pandemic, the Department was not directly involved in the procurement or distribution of PPE, healthcare equipment and testing and tracing for the health and care system, and therefore my role and responsibilities for procurement and distribution were limited. Prior to the pandemic:
    a. While the Department was responsible for the UK Influenza Pandemic Preparedness Programme and the policy of having a stockpile, PHE was responsible for the stockpile's storage and management;
    b. The NHS and social care sector were responsible for procuring PPE and medical equipment such as ventilators for their own usage. The NHS could choose to use NHS Supply Chain but did not have to do so. There was no central social care procurement resource;
    c. There was no test for the COVID-19 pathogen and no dedicated infrastructure for testing at scale.

34. The Department became involved in the above matters as part of its pandemic response, as a result of its role as Lead Government Department (LGD) for pandemic preparedness, response and recovery. As the shift to a DHSC-led response then changed to a government-wide response, the Department's role as LGD gave way to a cross-government approach to handling the pandemic, while the Department formally remained the lead government department for dealing with health and social care matters. Practically, overall policy responsibility for key decisions was taken over by the Prime Minister, evidenced by the COVID-19 Action Plan published on 3 March 2020 and the creation of the COVID-19 Taskforce in May 2020 overseen by Cabinet Office (**CW14/6 – INQ000057508**).

35. This shift meant DHSC and other departments became directly involved in, and responsible for in some instances, individual workstreams relating to procurement and distribution. DHSC's departmental Battle Plan shows where procurement and distribution

matters sat within the Department's pandemic response. I identify the allocation of responsibility for specific workstreams where relevant throughout my statement.

My role and responsibilities as Permanent Secretary in relation to procurement and distribution

36. I am asked to discuss my role and responsibilities in relation to matters within scope of Module 5. Where not otherwise provided in my statement, a detailed explanation of the relevant workstreams falling within Permanent Secretary-level responsibilities has been provided in the Department's corporate statements submitted to the Inquiry, including in relation to PPE and healthcare equipment and supplies including oxygen and ventilators, and testing. My statement focusses on matters that I was directly involved in, and I have endeavoured to outline all of the relevant actions I took. I have sought to provide a sufficient level of detail on each workstream where I consider it helpful to the Inquiry for me to do so.

37. Generally, my involvement in procurement and distribution throughout the relevant period related to matters of policy and strategy, for example, the decisions that PPE needed to be purchased against a RWCS (which meant that in 90% of scenarios, we would be buying more than was required), not in how that was to be delivered by individual contractors.

DHSC's departmental Battle Plan

38. I was involved in the development of the first version of the Department's COVID-19 Battle Plan, which was introduced to organise the Department's work in March 2020. The Battle Plan was, in my view, central to how the Department was managed during the pandemic. The Battle Plan initially identified seven workstreams in total, which informed the Department's decision-making role (**CW14/7 - INQ000056110**). Workstream (ii), which aimed to ensure supply of key products and equipment to the NHS including PPE and ventilators and (iii), which aimed to deliver widespread testing, are particularly relevant for Module 5.

39. The aim of the Battle Plan was to have a single overview of the Department's COVID-19 response and key actions, to track progress and to manage the cross over between the parts of the Battle Plan to be managed, to facilitate coordination, and to ensure that planning reflected agreed RWCS and other risk-based assumptions. The RWCS approach reflected the advice to the Department at the 28 January 2020 SAGE meeting to use the existing planning assumptions for an influenza pandemic to develop a RWCS

for COVID-19 in the UK.[1] The Department ensured, as far as possible, that its work under the Battle Plan workstreams aligned with the projects it was accountable for in accordance with the COVID-19 Taskforce.

40. The Department developed the Battle Plan over time. 5 further versions were produced:
    a. Version 2.0 (11 May 2020) (**CW14/8 - INQ000107087** to **CW14/11 - INQ000106506**);
    b. Version 3.0 (21 July 2020) (**CW14/12 - INQ000106542** to **CW14/14 - INQ000106544**);
    c. Version 4.0 - 4.2 (15 February 2021 – 27 June 2021) (**CW14/15 - INQ000111267; CW14/16 - INQ000234965**);
    d. Version 5.0 - 5.1 (3 August 2021 – 20 September 2021) (**CW14/17 - INQ000287671; CW14/18 - INQ000256990; CW14/19 - INQ000287686**)
    e. Version 6 (28 April 2022) (**CW14/20 – INQ000562468; CW14/21 – INQ000562469**).

Permanent Secretary-level oversight

Personal Protective Equipment (PPE)

41. I was not directly involved in the substantive decisions on individual contracts, PPE procurement or deployment. I was, however, aware of the development of PPE policy as it related to such matters, and I was copied into emails providing updates which, as I describe, would have been prioritised and summarised by my office. I also attended meetings where the issues were discussed with Ministers.

42. I was involved in the structural reorganisation within the DHSC and government that facilitated PPE procurement and distribution. This culminated in the appointment of Lord Deighton on 19 April 2020 as chair of the PPE Taskforce to lead the national effort to source PPE for frontline health and social care staff. Lord Deighton was initially tasked with co-ordinating the end-to-end process of design through to manufacture, including streamlining the approvals and procurement process to ensure domestic PPE supplies were rapidly approved. He subsequently took on a wider role overseeing our PPE sourcing as a whole. I set my role in respect of the organisation of PPE procurement and its distribution below.

[1] RWCS is a concept developed for emergency planning. The RWCS approach had been advised by the Scientific Pandemic Infections Group on Modelling (SPI-M) to DHSC to provide, in the event of an influenza pandemic, a consistent basis for pandemic response planning and assurance to planners so that they are able to respond to a wide range of scenarios should a hazard occur. RWCS is not a prediction or forecast of what will happen or what scenario is most likely, nor the worst theoretically possible scenario, but of the worst that might *realistically* happen.

43. I became aware of a 'high priority referral' route when others referred to it, but I was not involved in concluding that such a route was needed, nor do I remember being asked whether it should be created. My view is that the principle of triaging referrals and giving priority to the most promising was correct. The problems that arose were in how the prioritisation took place, with too great an emphasis placed on who made the referral, as opposed to the nature and promise of the lead. The criteria used to assess the proposal was the same for all matters of referral; the problem was not with differing standards of assessment, but with who got to the front of the queue. As a result, some less promising leads were given too great a priority.

Testing equipment

44. In the initial stages of the pandemic David Williams was responsible, as DHSC's Senior Responsible Officer (SRO), for the delivery of the testing programme and the implementation of ministerial decisions as set out in the Battle Plan. This was the case until Baroness Harding was appointed to lead the Government's test and trace effort on 7 May 2020.

45. Baroness Harding reported directly to the Prime Minister and Cabinet Secretary and was directly responsible to them (the test and trace programme would later transfer to the Department on 3 December 2020) (**CW14/22 - INQ000107093**). Ministerial accountability for testing and NHS Test and Trace remained at all times with the Secretary of State for Health and Social Care. As David Williams had agreed to act as Additional Accounting Officer for the Department, he was the responsible Accounting Officer for Test and Trace. David Williams therefore oversaw the financial management and governance of the Test and Trace programme, while day to day financial management and planning activity was undertaken by staff seconded into the Test and Trace team. I discuss the Department's approach to testing, leading to Test and Trace below.

Medical equipment - including ventilators

46. I was involved in the discussion about the setting up of a Ventilator Challenge, which was a Cabinet Office-led programme. My involvement was limited to discussing strategy during meetings with the Prime Minister. I was not involved in and cannot remember discussing any individual procurement decisions relating to ventilators.

Mutual aid

47. I had regular meetings with my counterparts in the Devolved Administrations (DAs), e.g. on 27 March 2020 (**CW14/23 - INQ000496795**). These meetings sometimes touched on the supply of PPE issues which I would then raise with the relevant officials.

Relationships with other government departments

48. I am asked about my working relationships with other government departments to the extent they are relevant to the subject matter of this module.

49. I had contact with BEIS and FCO, as I did with other government departments. I do not recall substantive discussion with BEIS in respect of matters relevant to this module and had limited contact with FCO in respect of the same. I remember, for example, exchanging emails with Christina Scott, a senior official in the UK Embassy in Beijing (**CW14/24 – INQ000562461**). Details of how the Department engaged with other Departments at official level are covered in the Department's corporate statements. I exhibit my diary which sets out some calls with various individuals during 2020 (**CW14/25 - INQ000562470**) and I exhibit the read out of those calls where available:
    - PPE next steps call (Cabinet Office, HM Treasury, Department for International Trade): 21 April 2020 (**CW14/26 - INQ000562462**); follow up meeting: 23 April 2020;
    - DIT: Call with Cabinet Secretary and Department for International Trade Permanent Secretary (Antonia Romeo): 28 April 2020 (**CW14/27 - INQ000562463**);
    - BEIS: Calls with Sam Beckett: 1 May 2020; 4 June 2020 (**CW14/28 - INQ000562464; CW14/29 - INQ000562465**);
    - Daily testing meeting 8 April 2020; anti-body testing senior discussion 1 May 2020;
    - FCO: Governance board meetings: e.g. 30 January 2020; 21 May 2020; 24 September 2020;
    - PPE Programme Oversight Committee (Lord Deighton, PPE Make; Trade; No. 10; Cabinet Office; HM Treasury) e.g. 23 June 2020;
    - Testing update: e.g. 14 April 2020.

50. In April 2020 there was discussion with the then Cabinet Secretary about seeking to spread work on pandemic response across government so that the whole burden did not fall solely on DHSC. This included involving the Department for International Trade and the Foreign Commonwealth & Development Office in PPE procurement.

51. In March and April 2020, I had two emerging concerns relating to the working relationship between the Cabinet Office and DHSC during the very early part of the pandemic. The first was that it was not always clear where decisions were being made prior to the introduction of the system of meetings via Covid S and Covid O which took place from May/June 2020. Secondly, the duplication of queries from the Cabinet Office created some difficulty. I was concerned at points that the valuable time of key DHSC staff, for example in procurement, was being taken up by having to explain to Cabinet Office staff what was going on.

52. This was obviously inefficient and unproductive. I raised my latter concern in WhatsApp exchanges with both the Cabinet Secretary and Tom Shinner on 25 March 2020 (**CW14/30 - INQ000279918; CW14/31 - INQ000279917**). My concerns were at their highest in April 2020 and declined after more rigorous systems were established.

Managing expenditure and placing orders

53. The Second Permanent Secretary David Williams managed expenditure and placed orders for procurement of PPE on a day-to-day basis. I was in continuous discussion with permanent secretaries across government who would raise issues with me that I would, in turn, pass on to the relevant team. This was usually speaking with each other on the phone, or during meetings.

Pandemic Influenza Preparedness Programme (PIPP) and Board

54. The Pandemic Influenza Preparedness Programme (PIPP) was the DHSC led programme for the health and social care system's planning and preparedness for any potential future influenza pandemic in England. The programme is governed by a programme board, the PIPP Board, which met for the first time in October 2007. The Board was chaired by the DG for Global Health and Health Protection. The Board was attended by representatives from NHSE, UKHSA, DHSC and the CO. The Board was responsible for setting the strategic aims and objectives of the programme and for coordinating the work of stakeholder organisations to meet these objectives. The Terms of Reference for PIPP are exhibited at (**CW14/32 – INQ000022804).** The papers and minutes from the Board are exhibited at (**CW14/33 – INQ000022863** to **CW14/80 – INQ000023074**).

55. The PIPP Board was responsible for delivery of the entirety of PIPP's work, including those areas where operational delivery was delegated to delivery partners such as NHSE and UKHSA.

56. As of November 2022, the PIPP formally transitioned to the Pandemic Preparedness Portfolio (PPP). This new broader programme of work reflected lessons learned from the pandemic including the need to be prepared for pathogen threats across the five routes of transmission (respiratory, vector-borne, contact, oral, sexual/blood), not just influenza. The PPP Delivery Board, established in November 2023 (**CW14/81 - INQ000184100**), chaired by the Department's Director of Emergency Preparedness and Health Protection, has responsibility for assuring delivery of the portfolio, of which PPE is one workstream.

Cross-government collaboration during the relevant period

57. In addition to the PIPP, DHSC and the CCS in the CO co-chaired a cross-government Pandemic Preparedness Board, called the Pandemic Flu Readiness Board (PFRB). PFRB was established in 2017 following Exercise Cygnus (a Departmental exercise simulating decision making during a pandemic) and included membership from OGDs and all Devolved Governments. Terms of reference for PFRB are exhibited at (**CW14/82 - INQ000022741**).

58. PFRB workstreams included: working across the whole of government, and with the Devolved Governments to develop draft legislation to support the response to a future influenza pandemic (the draft Pandemic Flu Bill which became the Coronavirus Act with some amendments); supporting departments to assess and improve the resilience of their sectors to operate in a pandemic, particularly in respect to a reduced workforce; establishing a group of experts and advisers to advise government on moral, ethical and faith considerations in advance of and during a pandemic (MEAG); working with MHCLG on local engagement around pandemic flu planning including advice on best practice through the development of a Resilience Standard; and improving plans of the health and care sectors to flex systems and resources to expand beyond normal capacity levels.

59. The responsibility of the PFRB was to:
    a. Oversee the delivery of the PFRB work programme and the delivery of associated outcomes and products;
    b. Provide an interdepartmental forum to challenge and question progress against milestones;

c. Coordinate the work programme of constituent departments and, as appropriate, the Devolved Governments, and to provide a forum for clarifying boundaries of departmental responsibility and manage any interdependencies between departments;
d. Agree arrangements for maintaining and assuring the capability to manage the non-clinical aspects of pandemic influenza; and
e. Where policy areas are devolved, provide a forum for exchanging best practice among the four UK administrations with a view to developing common approaches where appropriate within the UK overall constitutional arrangements.

60. By 2018, the PFRB had overseen the development of:
a. Improved plans of the health sector to flex systems and resources to expand beyond normal capacity levels;
b. Clear plans to prioritise and augment adult social care and community health care during a pandemic response;
c. Refreshed guidance for local responders on planning for large numbers of additional deaths, underpinned by a comprehensive analysis of capability across the country;
d. Updated planning assumptions for workforce absence and stress-tested plans from Lead Government Departments which have responsibility for particular sectors, covering both the peak and duration of workforce absence;
e. Confirmed UK Government policy content for a draft Pandemic Flu Bill, to be held internally and taken through Parliament if required, to support the response to a severe pandemic;
f. A comprehensive UK-wide pandemic influenza health-focused communications strategy; and
g. Options to ensure government thinking is supported by moral and ethical advice.

Pandemic preparedness programme

61. The DHSC pandemic preparedness programme was designed both to mitigate the risk of a pandemic and prepare to respond to a pandemic should one arise. Inherent uncertainty about the timing, characteristics and severity of pandemics mean it is not possible to forecast what the next pandemic will look like. Consequently, DHSC's pandemic preparedness programme was informed by the agreed RWCS as set out in the National Risk Register (NRR) **(CW14/83 - INQ000023104)** and National Security Risk Assessment (NSRA), latest scientific evidence, and lessons learned since the 2009 Swine Flu pandemic. Between 2009 and 2020, programme workstreams covered clinical

countermeasures, scientific and ethical advice, excess death management, legislation, RWCS impact mitigation (surge and triage), surveillance, data, strategy and guidance, communications, and governance and assurance.

Availability and supplies of clinical countermeasures

62. A core part of the Department's pandemic preparedness programme and strategy for responding to an influenza pandemic was ensuring the UK had rapid access to clinical countermeasures that could be deployed as part of the response. Through the oversight of DHSC, the UK Government maintained a centralised stockpile of relevant products together with contracts agreed in advance for the provision of further stock, the development of a pandemic specific vaccine, or the delivery of dedicated operational functions (for example, the National Pandemic Flu Service).

63. Management of stockpiles has been the responsibility of PHE since its creation in 2013 and is now the responsibility of UKHSA.

64. The end-to-end process that resulted in a pandemic preparedness stockpile comprised the following stages:
    a. Identifying the products to be held, based on expert and scientific advice (e.g. from NERVTAG, ACDP, JCVI). For example, NERVTAG advised on the Personal Protective Equipment (PPE) product mix **(CW14/84 - INQ000022737)** and the specific antivirals and antibiotics to be held to treat pandemic influenza patients.
    b. Modelling the volumes of products to be held, based on the RWCS planning assumptions for a 15-week pandemic wave. For PPE, this was to ensure enough PPE was available for the expected influx of patients requiring assessment or treatment for influenza (and related infections). Note the requirements did not include supplies for business as usual (BAU) services as these were not part of the central stockpiling programme.
    c. Policy advice and financial approvals, including on the balance of just-in-case (JIC) and just-in-time (JIT) contracts and funding secured through government spending reviews, led by DHSC.
    d. Procurement of the product, led by PHE.
    e. Storage and management of the stockpiles, also led by PHE.

65. Decisions about volume and type of products stockpiled were based on advice from NERVTAG, with a majority percentage held in centralised stockpiles on a JIC basis, with separate JIT contracts in place to provide the remainder. A larger quantity was held on a

JIC basis to facilitate rapid distribution in times of need and because of potential risks to supply chains in the event of a global pandemic.

66. The Pandemic Flu Clinical Countermeasures Management Board (CCMB) (PHE-chaired Board overseeing the procurement, management, and storage of clinical countermeasures, reporting into the PIPP Board) met on 9 October 2019 (**CW14/85 – (INQ000023078; CW14/86 – INQ000023080; CW14/87 - INQ000023079)**. This was their last meeting before the COVID-19 pandemic. The CCMB was scheduled to re-convene in March 2020 for their next meeting. The PHE-chaired CCMB provided governance and oversight of the necessary maintenance and management of the clinical countermeasure UK stockpiles and the agreements required to ensure that the UK was well prepared to respond effectively to a pandemic.

67. The levels within the pandemic stockpiles were reviewed as part of this meeting and the official stock levels were calculated at this point to contain approximately 323 million PPE items (including masks, aprons, gloves, respirators, eyewear, and respirators), approximately 43 million pharmaceutical items including antivirals and antibiotics, and a total approximation of 726 million clinical countermeasure consumables (including items such as boxes, syringes, paper towels, and cannulas).

68. The advice from NERVTAG, historically, was to stockpile aprons but not gowns. In June 2019, the advice changed on this issue, and NERVTAG asked the Government to procure 20 million gowns. I gave evidence on this issue during Module 3 (**CW14/88 - PHT000000124**, pages 15-18) at which I identified that the procurement of such gowns was following the normal governmental processes in operation at the time, and that the fact that gowns were not in the PIPP stockpile was not because of delay on the part of the Department. As I have discussed above, the PIPP stock did not contain gowns. NERVTAG had made an initial recommendation to include gowns in the stockpile for specific situations, including Aerosol Generating Procedures, in June 2019 (**CW14/89 - INQ000023057**) and confirmed the specification (sterile non/sterile) for the market analysis in November 2019.

69. Normal government procedures involved considerable checks and balances to ensure both value for money and fairness between suppliers. During the pandemic, these processes were accelerated, raising our risk profile, which in turn created different challenges surrounding quality. The existing procurement process, in place when the pandemic broke out, was not capable of delivering gowns at the required speed.

70. These numbers only account for JIC stockpiles, and do not account for orders of PPE and pharmaceuticals placed and delivered prior to January 2020. Furthermore, planned deliveries of antivirals and antibiotics for 2019/20 were in most cases either completed or brought forward for delivery before 31 October 2019 to prevent any potential EU Exit disruption. Further information about the activity undertaken by the Government in preparation for Brexit is set out below.

71. In October 2019, the CCMB also held an advanced purchase agreement (APA) contract to enable procurement of a Pandemic Specific Vaccine (PSV) for influenza. This provided the UK with reserved production capacity for more than enough PSV doses for the entire UK population and to be available within 4-6 months of an influenza pandemic outbreak.

72. In addition to specific products, the pandemic preparedness programme included a contract for an antiviral distribution service called the National Pandemic Flu Service (NPFS). The NPFS was designed to supplement the response provided by primary care during an influenza pandemic. If the pressures meant that it was no longer practical for all those with symptoms to be individually assessed by a doctor or other health care professionals, patients could triage themselves via an online and telephony service in order to access antiviral medicines.

Funding for pandemic preparedness clinical countermeasures

73. Programme funding for pandemic preparedness clinical countermeasures was provided for from within a broader DHSC-owned Vaccines and Countermeasures Response (VCR) budget. The VCR budget encapsulated funding for three programmes:
    a. The national vaccines and immunisations programmes
    b. The pandemic preparedness programme (PIPP)
    c. The emergency preparedness (CBRN) programme.

74. The table below shows spending in respect of the Pandemic Preparedness Programme (component (b) of the VCR budget) from 2013/14 to 2019/20. This reflects the actual cost incurred against the budget.

75. The below table reflects the cost of products covered by the PIPP budget. Detail of the PIPP stockpile is set out above. This includes the National Pandemic Flu Service (NPFS - at ~£2 million/year), the Antiviral Exchange Programme, the APA (at circa £40 million/year) and the storage and distribution of PIPP items among other pandemic flu related costs. The spending fluctuated year on year dependent on what procurements

were made, and the need to replenish stock which had expired and the costs of disposal of such stock. This variation in spending reflects the underlying profile of the PIPP stockpiles and is not due to changes in the prioritisation of pandemic preparedness. For example, in financial year (FY) 16/17 there was increased spending of circa £50 million to replace expired antivirals as part of the Antiviral Exchange Programme, in FY 18/19 there was a spend of circa £50 million to replace stock, and in FY 19/20 there was a significant cost increase in commencing the initial response to COVID-19.

Year	PIPP Budget Outturn £ million
19-20	164.995
18-19	102.033
17-18	53.244
16-17	106.415
15-16	63.264
14-15	64.516
13-14	104.93

Impact of EU Exit

76. In December 2018, Cabinet agreed that a 'no deal' EU Exit was the Government's 'principal operational focus', and this was communicated to departments. Consequently, DHSC, alongside all other government departments, changed its priorities. However, EU Exit planning and preparation had already been underway before this point, and the Department had focussed resources to prepare for a range of scenarios.

77. On 28 July 2019, the then Chancellor of the Duchy of Lancaster announced that "planning for no deal is now this government's No. 1 priority". When Boris Johnson MP became Prime Minister in July 2019 the new Cabinet agreed that 'no deal' was the Government's 'central focus', with additional actions to ramp up preparations including daily meetings of the EU Exit Operations (XO) Cabinet Committee.

78. As is usual practice across government, departments re-balance their resource when there is a major new government commitment to ensure there is sufficient focus on the new work. This was the case with EU Exit preparations, where the department needed

to prepare for a number of different scenarios. Both 'deal' and 'no deal' scenarios required work which increased the resilience of the health and care system, including some elements which were then of direct use in the pandemic response.

79. Following the scale up of EU Exit related work that took place across government in 2018, the Department's ExCo agreed to deprioritise other work in order to move resource to focus on EU Exit. This affected work across the breadth of the Department's responsibilities. For example, the Department scaled back some work on the social care green paper in 2018. Similarly, work was paused on new consultations on obesity policy, as well as a roundtable on Hepatitis (**CW14/90 - INQ000023029; CW14/91 - INQ000023032; CW14/92 - INQ000023031; CW14/93 - INQ000023030**).

80. In October 2018, the PIPP Board was notified of DHSC's decision to scale back some work related to pandemic preparedness and High Consequence Infection Diseases (HCID) **(CW14/79 - INQ000023073).** Work was paused on the development of guidance for NHSE on managing surges in the healthcare system, as well as on operationalising plans for adult social care. Furthermore, a refresh to the Influenza Pandemic Strategy from 2011, and the 2012 Communications Strategy, was paused. Similarly, the PFRB met in November 2018 and agreed to pause meeting until February 2020 (although the Board met in January 2020).

81. The Department continued to progress work on the development of the draft Pandemic Flu Bill, as well as continuing plans to re-procure a pandemic specific vaccine APA. DHSC also advanced plans to establish a programme of Tier 1 pandemic flu exercises to test the improvements made to preparedness since Exercise Cygnus. The PIPP Board met again in October 2019.

82. Some elements of EU Exit preparations created additional public health and system resilience which became useful during the COVID-19 pandemic. In 2018, the Department developed an extensive programme of activity as part of the Government's planning and preparation for the risks of a 'no deal' EU Exit. The Department's existing Emergency Preparedness, Resilience and Response (EPRR) function which led on the planning for and response to all incidents where there is a potential risk to the public's health was brought together with our work on preparing for a 'no-deal' EU Exit into the newly formed Operational Response Centre (ORC). This brought together our capability on emergency response and responsibilities as a Category 1 responder under the Civil Contingencies

Act 2004 (CCA) with our planning and preparedness to manage a potential 'no deal' EU exit.

83. The DHSC ORC led the health and social care preparedness and response for Operation Yellowhammer, which was a programme of work established to prepare for the potential disruption a 'no deal' EU Exit could cause. The creation of the ORC meant that when the COVID-19 pandemic arose, a better emergency response capability had already been created and the Department possessed a much better understanding of medicines and other supply chains related to health and social care equipment and goods as well as the impact of such disruptions on the health and sector.

84. The Department established a new Continuity of Supply programme to mitigate the risk of border disruption to the import of medicines and medical products from the EU. The UK is heavily reliant on imports from or via EU member states, in particular using what is known as the "short straits" (the routes between Calais/Dunkirk/Coquelles and Dover/Folkestone) for medical supplies: around three quarters of medicines are either manufactured in the EU or arrive in the EU before being sent to Britain, with the vast majority via the short straits. The Government's published RWCS planning assumptions noted the "unready Heavy Goods Vehicles (HGVs) could reduce the flow rate [at the short straits] to 40-60% of current levels" **(CW14/95 - INQ000023061)**. Working closely with industry, the NHS, and OGDs, a multi-layered approach was implemented **(CW14/96 - INQ000023059)**, which consisted of stockpiling around 6 weeks' worth of medicines and supplies (both government and private owned), supporting suppliers to get trader ready for new border checks, alternative ferry routes to avoid the short straits (equivalent of 2,603 HGVs per week of Government Secured Freight Capacity for medical products procured by Department of Transport) **(CW14/97 - INQ000023123)**, regulatory flexibilities and a dedicated emergency response function, including DHSC procured Express Freight Service for emergency product movements by air from the EU **(CW14/98 - INQ000023062)**. The programme was UK-wide and covered six product areas (medicines, medical technologies, vaccines, clinical trials, substances of human origin, and non-clinical goods and services, such as food and laundry).

85. The Department identified 10 workstreams in the EU Exit portfolio, which were:
    a. Continuity of supply - Ensure uninterrupted patient care in the health and care system by ensuring there is a sufficient supply of medical products across the UK.
    b. Reciprocal healthcare - Seek to establish alternative reciprocal healthcare arrangements between the UK and the EU27/European Economic Area (EEA)

countries as soon as possible and minimise the disruption of transition to any new arrangements.

c. Adult social care - Ensure continued care services for recipients (both publicly and privately funded) of adult social care services across England.
d. MHRA readiness - Ensure effective and uninterrupted regulation processes from day one in the UK.
e. Workforce - Protect the health, safety and interest of patients and staff by mitigating or responding to disruption to the health and social care workforce and strengthening the resilience of the sector.
f. Data - Ensure alternative transfer mechanisms are in place to enable data transfer from the EEA to England for the health and care system, including transfer of data stored in the EEA and access to data contained in EEA databases, systems, and networks; and to be ready to respond to any issues after exit-day where data is not flowing.
g. Health security - To maintain the UK's capability to prevent, detect, prepare for and respond to cross-border threats to health.
h. Overseas Visitor Cost Recovery - Put in place a legal framework for England and Northern Ireland and support implementation of the National Health Service (Charges to Overseas Visitor) Regulations 2015 in England.
i. Public health - Ensure continued functioning of the statute book for the UK.
j. Operational readiness and response - Ensure local, regional and national preparations are in place for adult social care services in England before day one of EU Exit, and development of emergency response arrangements.

86. When the date of EU Exit was confirmed in January 2020, there was some uncertainty as to the impact of the UK's withdrawal from the EU on public health cooperation. The Department agreed with the EU Commission on 30 January 2020 that information-sharing and participation in relevant meetings on COVID-19 would continue during the Implementation Period **(CW14/99 - INQ000023121)**.

87. While it is a matter of judgement, the Department's view, with which I agree, is that the UK was better prepared for health-related emergencies as a result of the work conducted on EU Exit. For example, on supply, the Department had a far deeper understanding of global medical supply chains and stronger relationships with industry, heightened stockpiles of critical medicines and medical products which provided an increased buffer to disruption, and an improved emergency response function, including provision for emergency logistics to mitigate disruption (since re-procured to enable imports from

anywhere in the world, and not just the EU) **(CW14/100 - INQ000023127)**. During the COVID-19 pandemic, the Department was able to use its existing stockpiles, the National Supply Distribution Response (NSDR) service and could quickly identify specific drugs that, for example, came from Wuhan thanks to these capabilities.

88. I gave evidence on this issue in Module 1 on 19 June 2023, where I said:

"We stopped a whole load of work which was about enhancing the flu plan and taking forward chunks of the flu plan, and we -- and that's clearly a negative, I'm not trying to imply that that is not a negative -- and we added a whole series of generic capabilities that we then used in the Covid response, and my reflection on that is that the capabilities that we built up as a byproduct of our no-deal Brexit work were extremely valuable to us in the pandemic. So, as I say, and just to be very clear, I am not trying to suggest that reducing the work that you showed earlier in some way enhanced us, it clearly didn't, it was -- clearly in an ideal world, if you had all the resources you want, you would do both, I am simply saying, in the balance of weighing up, those capabilities that I quote in my witness statement turned out to be, in my judgment, more valuable than more work on the influenza plan."

Personal Protective Equipment (PPE)

PPE before the COVID-19 pandemic

89. I had no specific personal role in preparing for the stockpiling, procurement and distribution of key healthcare equipment and supplies. My involvement was in substantive decisions regarding PPE but not in relation to individual contracts.

90. PPE in healthcare includes a variety of different items ranging from the widely used (e.g. gloves and aprons) to more specialist items (e.g. FFP3 respirators). Health and care providers sourced PPE from a wide variety of sources prior to the pandemic and it was their responsibility to organise such a supply. The NHS Supply Chain (managed by Supply Chain Coordination Limited (SCCL) from 2018, an ALB of the Department and a company wholly owned by the Secretary of State which operated as a management function for the supply chain which outsourced its buying function), did supply an estimated 56% of the NHS Trust requirement but there was no obligation to use this service, and some trusts purchased PPE directly from suppliers. Of course, the NHS encompasses more than just hospitals. Primary care providers, including GPs, opticians, dentists, pharmacists and community services procured mainly from wholesale suppliers.

Social care providers, which is made up of a variety of provision of a significant number of providers, some of whom are large commercial bodies but many of whom are small private enterprises or social enterprises or charities, and procured mainly from wholesale suppliers. PPE was largely sourced from overseas and there was extremely limited UK production.

91. As part of the Pandemic Influenza Preparedness Programme (PIPP), around 323 million items of PPE were stockpiled for pandemic response (**CW14/101 – INQ000057714** (*figure 4 of The supply of personal protective equipment (PPE) during the COVID-19 pandemic*). The Department took recommendations from NERVTAG as the relevant expert body on the stockpile items, and funding and procurement was agreed through the Spending Review process. Funding and procurement for stockpile was provided by DHSC and PHE arranged storage and maintenance. The stockpile included: including masks, aprons, gloves, respirators, eyewear, and respirators. The approach to stockpiles pre-pandemic is set out above. I also discussed the state of the PPE stockpile in the oral evidence I gave to this Inquiry on 12 November 2024 (**CW14/88 - PHT000000124**, pages 11 – 20).

92. As I have discussed above the PIPP stock did not contain gowns. NERVTAG had made an initial recommendation to include gowns in the stockpile for specific situations, including Aerosol Generating Procedures, in June 2019 (**CW14/89 - INQ000023057**) and confirmed the specification (sterile/non-sterile) for the market analysis in November 2019. The market analysis was being finalised prior to commencing the procurement exercise which was planned for early 2020. Gowns were subsequently procured as part of the wider PPE procurement effort. I discussed lack of gowns as set out above and in my oral evidence to this Inquiry.

PPE during the COVID-19 pandemic

93. As I have discussed above, I was not directly involved in the substantive decisions on PPE procurement or deployment, nor did I have involvement with individual contracts. I was, however, aware of the development of PPE policy, and I was copied into emails providing updates which would have been prioritised and seen by me as Permanent Secretary. I also would have attended meetings where the issues were discussed with ministers. I was also involved in the structural reorganisation of PPE procurement and distribution. I discuss my involvement below in context of the actions taken by the Department to procure and distribute PPE.

94. The emergency of COVID-19 resulted in unparalleled increases in global demand for PPE, and significant disruption to supply chains. Securing sufficient PPE and ensuring it was available to front line staff when they needed it was a major element of the Government's response to the pandemic.

95. On 10 January 2020, Infection Prevention Control (IPC) guidance for the care of suspected or known COVID-19 patients was first published **(CW14/103 - INQ000106903)**. COVID-19 was initially categorised as a HCID, which meant that any suspected cases would be managed as inpatients in a small number of fully equipped specialist centres around the country. HCIDs are acute infectious diseases, typically with a high case fatality rate requiring an enhanced individual, population and system response to ensure they are managed effectively, efficiently and safely. As a result, a higher level of PPE was required, including FFP3 respirators, fluid repellent disposable gowns, gloves with long, tight-fitting cuffs, disposable surgical caps and eye protection to be worn. This led to increased demand for PPE in the COVID-19 pandemic compared to what would otherwise be required for an influenza pandemic. I discuss the declassification of COVID-19 as an HCID at paragraph 100 below.

96. On 30 January 2020, NHSEI Incident response requested the convening of a Supply Chain Cell to assess existing supply and possible interventions which would need to be made. On 31 January 2020, the PIPP stockpile was made available for release to supplement the usual supply chains. Action was also taken to increase the procurement of PPE. On 7 February 2020, the Department instructed NHS Supply Chain to purchase additional volumes of PPE, both through existing suppliers and on the open market, and on 14 February 2020, NHS Supply Chain were given delegated authority to conduct additional significant spending on the open market for PPE items of most concern without the need for the direct approval of an authorising officer from the Department (**CW14/104 - INQ000106111**). At the end of February 2020, the UK Embassy in Beijing was mobilised to support the identification of, and dialogue with, prospective new suppliers for PPE.

97. In supporting the supply chain, the Department released its PIPP stock to the NHS and to wholesalers on 28 February 2020. On 18 March 2020, the decision was taken to provide 300 Type IIR facemasks (which are fluid-resistant and used when delivering direct care within two metres of a suspected or confirmed COVID-19 case) to each Care Quality Commission (CQC) registered care home and home care providers (25,245 providers) (**CW14/105 - INQ000106256**). An additional 23 million items of the PIPP PPE stock were released to designated wholesalers for onward sale to social care providers.

We made arrangements with seven wholesalers: Careshop, Blueleaf, Delivernet, Countrywide Healthcare, Nexon Group, Wightman and Parrish, and Gompels to supply PPE to CQC registered providers in the social care sector. For primary care providers in the community, we organised emergency drops of PPE by 10 April 2020. These were delivered to individual GP surgeries, community pharmacies, dentists, urgent dental centres and hospices across England. We also released PPE to wholesalers for onward sale to these providers. In total, 22 million items of PPE were made available in these ways.

98. On 16 March 2020, the Department stood up the National Supply Distribution Response (NSDR) hotline which operated 24/7, so that providers of health and social care had a number to call if they had an immediate and urgent need for PPE within 72 hours (**CW14/106 - INQ000107089; CW14/107- INQ000107090**). The role of the NSDR in the context of PPE supply is discussed in greater detail in the Department's corporate statement for Module 5 provided to the Inquiry.

99. On 18 March 2020, the Secretary of State agreed to request the use of the military to support PPE distribution, through Military Aid to the Civil Authorities (MACA) procedures **(CW14/108 - INQ000106259)**. A MACA request may be made in the event of an emergency in the UK whereby local emergency services provide the first response, but government departments or civil authorities may then request military assistance from the MoD. MACA provides deployment of clinically trained staff or other military capabilities such as logistics, security and construction. Requests can be made when there are issues with human resource in the health and social care sectors due to very high levels of staff absences or a sudden and unexpected increase in demand. Once requests are granted by the MoD, military staff will be made available as required.

100. On 19 March 2020, having assessed further evolving information, including fatality rates, the UK public health agencies declassified COVID-19 as an HCID **(CW14/109 - INQ000106267)**. Accordingly, IPC guidance changed to tailored guidance reflecting different care settings, whether the patient was known or likely to have COVID-19, and what clinical procedures were being undertaken. The guidance continued to develop as our understanding of the virus improved **(CW14/110 - INQ000106126** to **CW14/113 - INQ000106130).** The Department was not responsible for issuing the IPC guidance; this was led by PHE and NHS England.

101. On 21 March 2020, the Department agreed to establish the Parallel Supply Chain, a centralised buying and distribution system, to increase our capacity and capability to procure, ship and deliver PPE. Procurement experts from across government augmented the existing experts from NHS Supply Chain. NHS Supply Chain continued to work with their existing suppliers to secure additional supply. New opportunities were explored through a 'China Buy' workstream with the Beijing Embassy, a broad effort to secure new supplies which led to the open procurement launched on 10 April, and a 'UK Make' workstream focused on building up UK manufacturing capability. NHS Supply Chain, Clipper Logistics (a publicly limited company) and members of the armed forces developed the logistics pathways to provide PPE to the frontline. The logistics efforts supported daily deliveries to NHS providers, support to the Local Resilience Forums (LRFs) - who were responsible for delivery and organisation of the emergency response in local areas - and established an online portal for social care, primary care and others to secure PPE. Members of the armed forces worked with DHSC and NHSE colleagues to establish a coordination cell to direct the procurement efforts, make allocation decisions and manage the logistics.

102. On 23 March 2020, the Department appointed McKinsey to develop a single model for demand (**CW14/114- INQ000106355**; **CW14/115 - INQ000106356**). I was not involved with this appointment. Following a first iteration of modelling by McKinsey on 26 March, this model was stabilised on 12 April, pulling together planning assumptions, analysis and decisions about assumptions into one single tool, though development continued. To estimate demand for PPE, the model estimated the number of anticipated patient contacts and the PPE required for each on the basis of the IPC guidance. The model covered demand in the NHS and social care. Following the IPC guidance changes on 2 April 2020 **(CW14/110 - INQ000106126; CW14/112 - INQ000106313; CW14/111 - INQ000106235; CW14/113 - INQ000106130)**, the model was updated to include all patient contacts not just those for confirmed or suspected COVID-19 patients. This had a very significant effect on the modelled demand for PPE. It also added a further modelling challenge as the model now needed estimates of total patients treated in the NHS and not just the estimates of COVID-19 patients. The model was continuously refined during that period, for example to reflect changes in IPC guidance.

103. After an initial few weeks of deliveries sent to address immediate shortages, the system for delivering PPE to NHS Trusts evolved into a hybrid between distributing based on modelling 'push' and based on demand 'pull' distribution. In addition to considering the modelled push needs of different organisations from the Ready Reckoner model,

demand signals (i.e. requests for stock) were also considered. These were improved over time as more data became available allowing refinement of the approach, for example from mid-May 2020 onwards, the Department began to receive information on stock positions from NHS Trusts, initially from the London area. This information enabled distribution to be tailored to Trusts' existing stock position rather than being pushed stock irrespective of their actual stock levels. By late summer the Department had a consolidated view of the 'run-rate' demand for PPE each month.

104. Healthcare Ministerial Implementation Groups (HMIG) were one of the groups of committees which the Cabinet Office organised at the beginning of the pandemic. It met on 2, 7, 9 and 17 April and discussed PPE as well as other COVID-19 issues **(CW14/119 - INQ000106317; CW14/120 - INQ000106341)**. The initial meeting focused on the approach to collating and managing demand across the UK; prioritising and distributing existing supplies; publishing updated PPE guidance; and a joined-up public sector approach to procurement.

105. Health Ministers from the four nations met on 31 March, with subsequent meetings at official level on 7, 14 and 17 April, to coordinate efforts and ensure mutual aid between the nations. In April, a Four Nations protocol was developed that shared PPE stocks across the four nations of the UK on the basis of population **(CW14/121 - INQ000106392; CW14/122 – INQ000106394; CW14/123 - INQ000106398)**. The principles underlying the protocol were:

a. UK Government procured PPE would be shared on a population basis between each of the UK four nations;
b. Each nation will continue to be ultimately responsible for and pursue PPE to meet its own population needs;
c. There will be transparent sharing of stock and supply information by the four nations to enable UK Government procured PPE to be shared on an equitable basis;
d. Mutual aid will operate alongside the protocol i.e. if a particular nation requires a particular item, it will be shared where possible; and
e. The scope of the protocol is Health and Social Care only.

106. On 2 April 2020, the IPC guidance was changed such that the use of PPE was advised for all episodes of care rather than known or suspected COVID-19 patients (**CW14/110 - INQ000106126**; **CW14/112 - INQ000106313**; **CW14/111 - INQ000106235**; **CW14/113 - INQ000106130**). The updated guidance reflected the fact that coronavirus was now widespread in the community, meaning clinicians were more likely to see patients with

the virus. This stated "where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector" then staff should wear an apron, Type IIR mask and gloves when assessing or providing direct care to a patient/resident which is not a possible or current COVID-19 case. Staff performing Aerosol Generating Procedures (AGPs) (the IPC cell having taken and considered expert advice and evidence which was discussed in some detail in Module 3 as to what was an aerosol generating procedure) were also directed to use gowns, FFP3 filtering respirators and face shielding visors. This was an enormous change driving a significant increase in the need for PPE across a wide range of settings.

107. On 3 April 2020, the Department, working with DLUHC, confirmed that it would set up an emergency PPE supply route to a network of 37 Local Resilience Forums (LRFs) (LRFs being the organisations who managed pandemic planning and emergency response for local authorities) to meet urgent local demand for PPE, working closely with them to understand their needs across a number of settings. These stocks were primarily being used by LRFs for health and care settings. This PPE was also used for wider public services where LRFs identified need and in line with the priority criteria set out in the clinical guidance published by the Department and PHE on 2 April 2020 (including care homes and home care, hospices, children's homes, General Practitioners and funeral directors). The first drop to LRFs took place on 6 April. Over 30 million items including aprons, gloves, Type IIR masks, eye protection, FFP3 masks, cleaning equipment and clinical waste bags were issued.

108. On 10 April 2020, the Department published its first PPE plan 'Covid 19: Personal Protective Equipment (PPE) plan' (**CW14/124 - INQ000106347**), which set the approach to three critical issues: PPE guidance; delivery of PPE to front line staff and future supply of PPE. Alongside the plan the Government issued a public call to action to support the scale of PPE now required to protect frontline staff (**CW14/125 - INQ000106345**). The Department received 24,000 offers of help and support received within a 14-week period from over 15,000 suppliers. A small proportion of offers - approximately 430 of the 24,000 - were initially processed through a 'high priority referral' route. All offers went through the same financial and quality assurance due diligence processes.

109. On 17 April 2020, in the light of the challenges in the continued supply of PPE (specifically the risk of the supply of gowns running out), infection prevention control clinicians in PHE and the NHS created the "Acute Shortage Guidance" **(CW14/126 - INQ000106360; CW14/127 - INQ000106357; CW14/128 - INQ000107091; CW14/129 -**

INQ000106358) providing guidance on alternatives, reuse and sessional, rather than single, PPE use. MHRA issued the guidance via a Central Alerting System (CAS) alert. The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. This guidance was withdrawn in September 2020 when there were no longer acute shortages.

110. On 19 April 2020, the appointment of Lord Deighton by the then Secretary of State for Health, Matt Hancock was announced, initially to spearhead 'UK Make' by ramping up manufacturing of PPE from UK-based companies, then subsequently to lead the PPE taskforce, supporting the Government's efforts to secure sufficient supply of critical PPE and ensure this gets to where it is needed, including driving forward coordination of the end-to-end process design.

111. An online ordering system (the 'PPE Portal') was established from 20 April 2020. It initially focused on primary care and smaller adult social care providers to establish further access to PPE before growing to include any eligible health and social care setting in England (over 58,000 settings, predominantly non-acute services). It was delivered through the Department partnering with eBay, Clipper logistics, Royal Mail, the NHS, Volo and Unipart, designed initially to be an emergency 'top-up' system of PPE for COVID-19 needs before increasing in scale to meet eligible providers' modelled requirements for COVID-19 PPE (e.g. masks, eye protection, gloves, aprons, gowns etc.) and associated stock (e.g., hand hygiene products). By the end of June 2020, the majority of eligible GPs and smaller adult social care providers (both domiciliary and residential) were able to register on this ordering portal. Throughout the summer of 2020, further sectors were able to use the portal (including dentists, orthodontists, pharmacies, optometrists and larger adult social care providers) and an increased range of product offerings were made available. In July 2021 LAs and LRFs were invited to register for the PPE Portal.

112. Guidance introduced universal face masks and face coverings in health and social care settings on 15 June 2020 (**CW14/130 - INQ000106399**). This increased requirements for Type IIR mask use.

113. As information about the virus and the PPE requirement changed, the PPE programme introduced the Sales and Operational Planning (S&OP) process in early June. This was

a comprehensive and robust process for estimating future demand for PPE based upon a range of considerations including past distribution, assessments of baseline demand, projections of trends and direct customer data. As soon as the Department was confident it had secured PPE supply for the health and care system to cover the immediate two-week period and the following 90-day period it gave the instruction to stop buying. The dates of these instruction by item are shown in the table below.

PPE ITEM	INSTRUCTION TO STOP BUYING
All Critical PPE	
Eye Protection	16 June 2020
Hand Hygiene	18 June 2020
Type IIR facemasks	24 June 2020
Clinical Waste Bags	26 June 2020
Aprons	26 June 2020
Gloves	26 June 2020
Gowns	29 June 2020
FFP3 Facemasks	30 June 2020

114. During the period 1 August 2020 to 31 July 2021, over 10.5 billion items of PPE were distributed to the health and care sector. The Parallel Supply Chain that was established shortly after the outset of the pandemic ensured that acute shortages of PPE ceased during this period. The ePortal ensured the supply of free PPE to over 50,000 social care and primary care providers.

115. On 25 August 2020, approximately 30,000 items of PPE were delivered to schools and further education institutions (**CW14/131 - INQ000234452**). This included Type IIR face masks, aprons, gloves, and visors, as well as hand sanitiser. The PPE was provided by the Department at no charge to help build resilience across the education sector to respond to suspected cases of COVID-19 arising in schools and colleges in advance of all pupils returning to school in September 2020.

116. On 9 September 2020, with agreement from the Secretary of State, the Acute Shortage Guidance was withdrawn by the IPC Cell. This advice was contingency planning in place during exceptional circumstances at the start of the pandemic (although it was never

implemented in practice) and was withdrawn on the basis that the UK now had a healthy PPE stock position.

117. On 28 September 2020, use of the PPE Portal (the Portal) which was designed to be an online ordering system for health and social care settings, had significantly increased. Most sectors that Local Resilience Forums (LRFs) had been supporting had been invited to use the Portal though there were several residual services, such as personal assistants, unpaid carers and education and childcare services that were not eligible. The Department asked LRFs to continue supplying these with PPE directly.

118. On 28 September 2020, the PPE Strategy was published by the Department, reiterating the offer of free PPE for health and social care providers until the end of March 2021, which sought to provide confidence in UK supply of PPE (**CW14/132 - INQ000234522**). The strategy set out how the Government was moving beyond the emergency COVID-19 response to stabilise and build resilience through getting a clearer view of demand, developing a more resilient and diverse supply chain, and building up a stockpile of PPE. Amongst other things, the strategy outlined the steps the Department had taken to establish a strong domestic supply base through 'UK Make' and to create a four-month stockpile available across all categories of PPE to accommodate any future surge to be in place by November 2020.

119. On 25 November 2020, National Audit Office (NAO) published a report on the supply of PPE and on 26 November 2020, NAO published findings of its investigation into Government procurement of PPE (**CW14/101 - INQ000057714; CW14/133 - INQ000234626**).

120. The final report for the Boardman Review of Cabinet Office COVID-19 Communications Procurement was published on 8 December 2020 (followed by a review with a government-wide scope on 7 May 2021), which provided recommendations that could be applied across government departments and procuring bodies **(CW14/134 – INQ000055888**; **CW14/135 – INQ000055876**).

121. I agree with all the findings and conclusions made.

122. On 25 January 2021, the Department issued communications to local authorities and LRFs about supplying free PPE to unpaid carers who did not share a home with those

for whom they cared (all 151 local authorities then supported these unpaid carers) (**CW14/136 - INQ000059659**).

123. The Public Accounts Committee published a series of recommendations to the Department on 10 February 2021 in light of the NAO report and other commissioned reports and reviews, including, at this stage, the first report published within the Boardman review. These included:

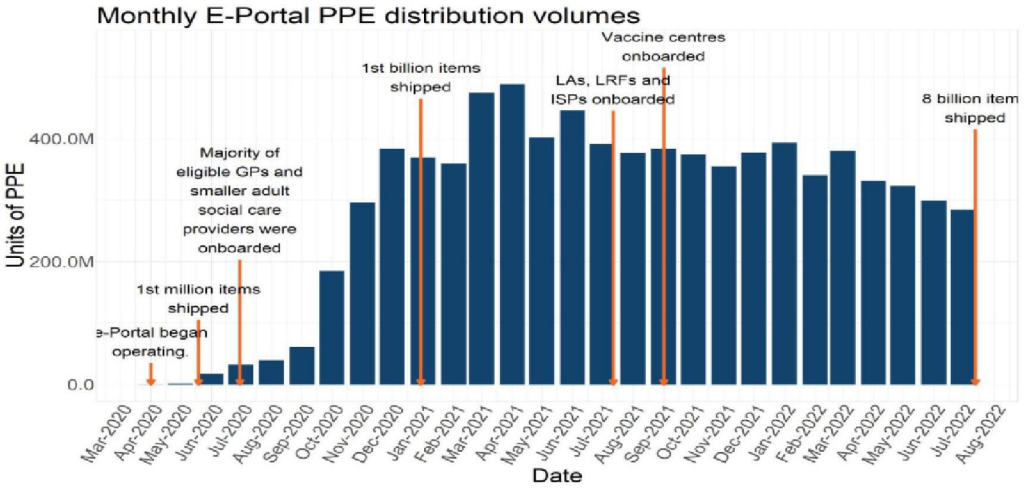
a. Ensuring the recommendations from the Boardman review were implemented across government;
b. Improving the approach to managing and distributing stocks of PPE;
c. Publishing lessons learnt from the procurement of PPE during the pandemic;
d. Revising emergency response plans to better consider who was supported, how and when; and
e. Improving understanding of the experience of frontline staff, particularly focusing on those from different ethnic backgrounds. The Department, working alongside NHS England and PHE along with other organisations, had taken a significant number of steps to do this which led, for example, to the commissioning of a wide range of masks to fit different face shapes and sizes, including of FFP3 masks to help ensure the passing of fit-tests in settings where FFP3 mask use was advised.

124. The final report for the Boardman Review of Government Procurement in the COVID-19 pandemic was published on 7 May 2021, as referred to above.

125. In July 2021, local authorities and LRFs were invited to register for the PPE Portal themselves. The vast majority of local authorities and LRFs then submitted regular orders to the Portal, which they received and then distributed to the various sectors they were supporting.

Date	e-Portal Developments
August 2020	Further sectors in both primary care and social care were invited to register.
September 2020	On 17 September 2020, the EU Commission approved the state aid notification for the PPE portal scheme to move from Emergency top up to the main distribution route. Hence, a broader range of sectors registered, more types of PPE available using the e-Portal, and the order limits on

	accounts were adjusted - for example to reflect updated government guidance on PPE use.
June 2021	Public services overseen by other OGDs including the police, Human Fertilisation and Embryology Authority (HFEA), the HO, HM Revenue and Customs (HMRC) and Department for Work and Pensions (DWP) were invited to register.
July 2021	Local authorities, LRFs and independent sector providers were invited to register. Independent sector providers include providers who undertake NHS contracts for diagnostic and therapeutic work and mental health providers.



126. Between 9 April 2020 and 30 September 2022, 8.75 billion PPE items were ordered through the e-Portal (**CW14/138 - INQ000235007**).

Reflections on DHSC's preparedness: stockpiling of key healthcare equipment and supplies

127. I have discussed the approach to stockpiles pre-pandemic above which led to the PIPP stockpile of 323 million items of PPE including masks, aprons, gloves, respirators and eyewear. The stockpile was established in 2009, after the swine flu outbreak and was based on assumptions that: (i) an influenza pandemic would last around 15 weeks; (ii) PPE would be needed for hospitals only and for those patients with influenza (who would be symptomatic) (**CW14/139 - INQ000184643**); (iii) and that the items to be supplied would be those required for influenza, not for all possible respiratory illnesses.

128. The stockpile was invaluable but ultimately insufficient for the COVID-19 pandemic which resulted in unparalleled increases in global demand for PPE. The size of any future stockpile will obviously be a key decision for this and future governments to decide. As the Department has identified in its evidence to the Inquiry to date, it is important to prepare for future pandemics which may well be transmitted by different routes of transmission (such as by insects or sexual transmission) which would require very different countermeasures to a future respiratory pandemic. Given, however, that the most likely future pandemic is one of influenza, the Government has stockpiled and continues to stockpile relevant medicines and clinical counter measures for this and other respiratory viruses. That, however, cannot and should not be the answer to a future pandemic. While stockpiles are a vital component of dealing with the early stages of a pandemic, they cannot be, other than through unfeasible expenditure, the answer to the whole of a pandemic response.

129. The need for such a stockpile, as well as the size of it, must be examined taking into account the significant financial costs arising from its maintenance and the possibility that the Department could spend very large sums of money on a stockpile that is never used or turns out to contain the wrong items for the next disease. Equally, PPE degrades over time, which means the Department must consider disposal options in parallel with defining the size of a stockpile it intends to hold. The Department has estimated that maintaining a stockpile of the size needed for the COVID-19 pandemic would have been substantially more expensive than buying in the pandemic even at inflated prices (**CW14/140 - INQ000279940**).

130. The UK does not have a significant manufacturing base for many PPE supplies and other forms of ancillary medical equipment, and in reality it is unlikely that such a manufacturing base will emerge given that the cost of purchasing those goods manufactured in this country would be significantly greater than purchasing them from those countries which currently manufacture such items. Furthermore, as the pandemic showed, even if there were manufacturers who could "convert" themselves to making relevant products, raw materials were not available. In any future pandemic, the Government must recognise and take steps to seek to organise surge procurement recognising that equipment is highly likely to need to be sourced and brought in from abroad. Likewise, the majority of medicines are not manufactured in the UK and so any future pandemic planning has to recognise that these will need to be procured and flown in from abroad.

131. The Department's response to the rapid rise in PPE demand is detailed at length above. The outline provided here pertains only to my personal recollection as events unfolded.

132. There were two distinct challenges in dealing with the unprecedented demand for PPE: the difficulty in sourcing the required PPE and importing it into the UK, and the subsequent issue of distribution and delivery.

133. David Williams sent a submission (which I had discussed with David and agreed with) to the Secretary of State for Health on 27 March 2020 which explained that "necessary spend on the coronavirus response may mean that the Department and its ALBs are unable to live within the level of resources authorised for 2019-20 by Parliament through the Estimates process" (**CW14/141 - INQ000551296**).

134. The 27 March 2020 submission explained "the Department and the NHS are fully committed to tackling CoVID-19 and we have been working on the basis that availability of funding should not prevent the right actions being taken at pace. We have been working closely with HM Treasury officials who concur with this approach, reflecting the Chancellor's Budget announcements whilst applying proportionate scrutiny and due diligence to rapid spending decisions." This submission identified that in order to purchase the PPE required, because of the global scramble for materials, there was going to be a greater risk than would be usual:

> "I also want just to put on the record that for certain categories of spend (e.g. PPE, testing equipment, ventilators) we are dealing with unknown foreign companies, seeking cash payments in advance in foreign currencies and sometimes with limited ability to demonstrate that the stock we want is available in the quantities we are contracting for. In normal circumstances this would be a concern on both grounds of propriety and value for money given the risk it poses either of loss or fraud. We are applying sensible due diligence where we can, including through assurances provided by our Embassies abroad and through Cabinet Office commercial experts, consistent with the need to move at pace, but these are not fool proof. <u>These are not, however, normal circumstances and Chris Wormald and I are both comfortable from an Accounting Officer perspective that a higher risk appetite here is entirely appropriate</u>. It would be helpful to confirm this is in line with your own risk appetite. Given the circumstances, <u>we are also spending on a precautionary or "no regrets" basis even if</u>

in the end not everything we buy is needed or can come onstream in the timelines we will need.

...

We have streamlined our approvals and scrutiny to be agile as required. We continue to work with HMT to apply proportionate due diligence and agree approval envelopes. I am satisfied this allows us to respond as quickly as needed while maintaining appropriate safeguards."

135. I supported David's comments and agreed with him both that this advice was needed and that we needed to recognise a greater risk appetite. The Secretary of State confirmed his agreement with this approach on 28 March 2020 (**CW14/142 - INQ000551297**).

136. I wrote to the Secretary of State on 28 March identifying that new COVID-19 related expenditure could not be contained within the Departmental Expenditure Limits approved by Parliament through the Estimates process and requesting a formal ministerial direction that such limits could be exceeded; this was approved on 29 March 2020.

137. The demand for PPE far outweighed the supply available globally, with many countries around the world trying to buy the same thing, and so the Department had to pay prices that would not have been usual pre-pandemic but given the global scramble for equipment, these were the prices that the market required that we pay to ensure continuity of supply of these critical safety items. There were significant challenges in securing the stock, largely from China and other countries which made these materials.

138. In total, the Department purchased approximately 38 billion items of PPE centrally at a total cost of £13.6 billion between 1 April 2020 and 31 March 2024, which were distributed onwards to the NHS and wider health and social care settings free of charge.

139. Of this, £10 billion has been recognised in impairment and write-down charges, of which only £19 million has been incurred in 2023-24. The costs of £10.0 billion included:
    - Reductions in market value to reflect current prices for items that were suitable for use and expected to be used – approximately £6 billion.
    - Impairments for items which were suitable for use, but were not expected to be used in advance of their expiry dates – approximately £1 billion.
    - Impairments for items that were either not suitable for use at all, or were unsuitable for use in health and care settings – approximately £3 billion.

140. As is demonstrated, the vast majority of write down relates to change in market value, or flows from the decision to buy for the RWCS, which meant a conscious decision was made that in 90 per cent of scenarios, we would overbuy. It is of course positive that we never reached the levels of Covid suggested by a RWCS. Between 1 April 2020 and 31 March 2024, the Department has reported cumulative losses of £8.1 billion, of which £6.5 billion has been reported in 2023-24. These losses are not in addition to the £10.0 billion costs already reported and as such do not represent additional costs to the taxpayer. The losses described relate to items that:

- are unsuitable for any use, or unsuitable for use in health and care settings (classified as fruitless payments);
- are suitable for use but are surplus to requirements and have either been disposed of during 2023-24 or were expected to be disposed of during 2024-25 (classified as constructive losses).

		Cumulative Losses	Loss cases reported in more than one year	Data quality adjustments	Losses reported in 2023-24	Cumulative loss reported in 2022-23
Fruitless payments	Cases	700	(149)	(2)	447	404
	£'000	3,311,816		(32,711)	2,385,370	959,157
Constructive losses	Cases	1,286	(670)	2	1,020	934
	£'000	4,782,811		410	4,074,688	707,713

141. We had to very quickly develop protocols and set up and run an enormous distribution and supply chain to clinical settings which did mean that PPE was prioritised in particular in the periods between March and June 2020. We also worked across the four nations of the UK to share stocks of PPE.

142. Alongside the challenge of securing international supply, there were significant challenges in distributing PPE to social care as a consequence of the sheer number of providers all over the country. Very few of these providers had their own stocks already in place, which further exacerbated the demand. There was no established central mechanism for distribution of PPE (or other supplies) to social care. Social care providers relied on private sector wholesalers for their supplies. I have outlined the measures taken in response to these challenges above. They were, in summary:

a. The release of PIPP stock to wholesalers during the very early stages of the pandemic.

b. The provision of 300 Type IIR facemasks from the PIPP stock to each CQC registered care home and home care providers in March 2020.
c. The activation of the NSDR hotline to allow health and social care providers to obtain PPE in an emergency from 16 March 2020.
d. Support of PPE distribution provided by the military through MACA procedures from 18 March 2020.
e. On 1 April 2020, SCCL informed health and social care providers of the activation of the Parallel Supply Chain.
f. From 2 April 2020, an existing NHSE capacity tracker for CQC registered ASC providers was upgraded to collect data on their PPE stock needs on a daily basis. This showed which care homes were likely to have shortages in the next 48 hours or in the next 7 days.
g. Drops of PPE supplies to local authority LRFs to allow them to provide PPE to local users including social care by 10 April 2020.
h. The establishment and scaling up of the PPE portal to allow various sectors of care providers to access PPE which took place between the pilot phase beginning late March 2020, most eligible GPs and smaller adult social care providers able to register with the Portal by end of June 2020, and all community and care settings granted access by September 2020.

143. The scale of the challenge faced in PPE deployment was unprecedented, perhaps most reflected by the Chief of the Defence staff's (Sir Nicholas Carter) comments at the time: "I would say in all of my 40 years of service this is the single greatest logistic challenge I've come across" (**CW14/143 - INQ000279949).**

144. At the beginning of the pandemic, the distribution of PPE could not keep pace with the changing requirements. On 19 March 2020, Infection Prevention and Control guidance on PPE was tailored to reflect different care settings, whether the patient was known or likely to have COVID-19, and upon the nature of the clinical procedure (**CW14/109 - INQ000106267**). On 2 April 2020, a significant change was made when PPE was advised for all episodes of care rather than known or suspected COVID-19 patients, reflecting the fact that coronavirus was already widespread in the community (**CW14/144 - INQ000279922**). By 15 June 2020, guidance introduced universal face mask and face coverings in health and social care settings (**CW14/130 - INQ000106399**).

145. I would describe the ability of the Government to obtain and then distribute PPE between early March 2020 - July 2020 as extremely difficult. In terms of supplying to the

nation, this was a challenge faced globally and France, Germany, Spain, Italy, Sweden, the Netherlands, Ireland, Denmark, Belgium, Finland, and Austria have experienced similar challenges to the UK in sourcing PPE.

146. The requirements from early April 2020 to require supply significantly more PPE to all health and social care settings for all of those working within them, alongside PPE's necessity in other settings put pressure on stocks and distribution and there were shortages in some hospitals, care homes and other settings during this period. There was also the entirely understandable fear of running out of PPE which was felt by many of those working in health and social care settings, so that they would only have 24 hours' worth of stock left before an emergency supply arrived. There were particular difficulties with the practical distribution of PPE into social care settings between March – June 2020, given the sheer number of places to which they had to be distributed and the fact that they – unlike hospitals – did not operate a "24 hour" reception service. The UK did not run out of PPE nationally, although this did require shortage protocols and there were local areas where supply was exceptionally challenging, particularly because of distribution issues.

147. I recognise that there has been significant criticism from those working in health and social care, and those in receipt of such care, that they were not being protected adequately and that they were being asked to ration PPE which would not keep them safe. These concerns were completely understandable. Regardless of the national position, individuals and local institutions faced considerable difficulties and the concerns felt by many individuals were justified. This was also in a situation where knowledge was still emerging about how COVID-19 was transmitted and of its effects, so anxieties and fears were naturally high across all of our society. I recognise and acknowledge the understandable concern from those who felt let down by the Government. This was something we were conscious of and which we sought to try and resolve as quickly as we could. We were painfully aware of these challenges and put in our best efforts to mitigate these situations, hence the setting up of various ways to try and distribute PPE and to enable those who required emergency stock to ask for it. Whilst we believed at the time and continue to believe we were doing our best in exceptionally challenging circumstances, this was of course no comfort to a health or care worker who was struggling to access the protection they needed.

148. I have been asked whether I remember the Secretary of State telling the Prime Minister or anyone else that "everything was fine on PPE" in April 2020. I do not

remember such a statement being made. If such a statement was made by anyone it was not accurate.

149. There was a dispute between the Secretary of State and Sir Simon Stevens in April 2020 about PPE distribution. I remember that the Secretary of State was due to be at a meeting in No. 10 alongside Emily Lawson who was the head of commercial at NHS England and who, alongside Jonathan Marron, Director General within DHSC, were responsible for sourcing and organising PPE. Emily Lawson did not attend that meeting. The Secretary of State believed that Sir Simon Stevens had ordered her not to attend this meeting as he did not want the NHS associated with the PPE challenges at the time. I remember that Matt Hancock did lose his temper in the meeting and asked where Emily Lawson was. I do not remember, however, Matt Hancock ever blaming Sir Simon Stevens for shortages. Sir Simon Stevens and Matt Hancock did have disagreements about PPE and the role of the NHS on reporting on it, but not about shortages, as everyone agreed it was a joint problem for the NHS and the Department to solve together. We set up a "joint cell" to work on this involving both NHS England and the Department working under Lord Deighton. This joint cell worked extremely hard and was able to both source and distribute PPE. I cannot remember Matt Hancock ever saying that the Treasury had "blocked approvals".

150. The decision to enter lockdown in March 2020 had in my view nothing to do with shortages of PPE or distribution, and decisions were not to my knowledge made about using non pharmaceutical interventions (NPIs) on the basis of what PPE was available. However, PPE was a relevant component of any exit strategy and the need for confidence in PPE was included as one of the five criteria needed to be achieved before the Government lifted lockdown measures in April 2020.

Testing

Procurement of PCR testing equipment and LFTs during the pandemic

151. Testing is one of the four available tools in tackling a new virus. The UK developed a test quickly and was able to share this knowledge with the rest of the world. At the start of January 2020 there was no test for the novel pathogen, COVID-19. Initial guidance was given by the World Health Organization (WHO) on 10 January 2020, recognising that the causative agent of the virus had not been verified and the gene sequence of COVID-19 had not yet been published (**CW14/145 - INQ000106556**). On 17 January

2020, the WHO published further guidance recommending that a polymerase chain reaction (PCR) test should be developed (**CW14/146 - INQ000106044**).

152. At this stage, the UK possessed no dedicated infrastructure for delivering any testing at scale. In January and February 2020, the UK Advisory Committee on Dangerous Pathogens (ACDP) designated that COVID-19 testing could only be conducted in secure laboratories that met certain standards. This explains the limitations on ramping up testing capacity at the time.

153. However, by the end of 2020 very significant technical development and scale-up of testing capacity had been achieved. There was capacity for over 200,000 PCR tests and 120,000 antibody tests to be conducted a day. All symptomatic people could access tests through a variety of channels, in person and at home; and several separate priority testing schemes e.g. for hospitals and care homes were being supported.

154. Prior to the appointment of Baroness Harding to lead the Government's testing and tracing effort on 7 May 2020 Second Permanent Secretary David Williams was responsible as DHSC's Senior Responsible Officer for the delivery of the testing programme and the implementation of ministerial decisions as set out in the Battle Plan above.

DHSC's approach to testing

155. SAGE minutes for 28 January 2020 record that a specific test was expected to be ready by the end of that week with limited capacity of 400-500 tests per day with guidance being rolled out to laboratories across the UK (**CW14/147 - INQ000057492**). At this stage the accuracy of the test was unknown because of the lack of knowledge about the disease. At the start of February 2020, UK testing for COVID-19 had started at a PHE testing laboratory in London. Our testing capacity increased over the course of the month, as the test developed by PHE was rolled out to a further 12 laboratories across the UK. In mid-March, testing capacity had reached circa 5,000 per day.

156. The initial focus was to increase laboratory capacity for PCR tests and in parallel expand eligibility for these tests and access to them through additional test sites. The drive to increase laboratory capacity started with expansion in the existing 'lighthouse laboratories' to increase their throughput and added new laboratories to the network, culminating in the opening of the new Rosalind Franklin 'mega laboratory' in June 2021.

157. Testing capacity started to increase from March 2020 (**CW14/148 - INQ000234854**). NHS Test and Trace, supported by the Department, increased both laboratory capacity for PCR tests and introduced new forms of testing, most notably lateral flow testing. In parallel, as capacity increased, both the eligibility and channels for provision of testing (for example increased 'local test sites' and test delivery by mail) also increased culminating in the launch of the 'universal offer' of testing for all residents in England on 9 April 2021 using lateral flow tests. Testing volumes peaked in March 2021 with over 2.3 million tests reported at the end of March 2021. I discuss the increase in testing capacity and contemporaneous developments in prioritisation policy in period March-July 2020 further below.

NHS Test and Trace

158. Baroness Dido Harding was appointed as Executive Chair of NHS Test and Trace on 7 May 2020 to lead the Government's testing and tracing effort. The NHS Test and Trace service was launched on 28 May 2020, which represented the Government's decision to rapidly expand the UK's testing and tracing capacity and to enable the loosening of restrictions. This was to help identify, contain and control COVID-19 so as to reduce the spread of the virus and with the aim of saving lives (**CW14/149 - INQ000107094**). The programme increased laboratory capacity for PCR tests and introduced new forms of testing, most notably lateral flow testing.

159. NHS Test and Trace's contact tracing component meant anyone who tested positive for COVID-19 was contacted by NHS Test and Trace and asked to share information about their recent interactions. Where close contacts (those either in direct contact with or within 2 metres of that person for more than 15 minutes) were identified, those close contacts were required to stay at home for 14 days (even if they had no symptoms), so as to stop unknowingly spreading the virus. Test and Trace also provided contact tracing and support for isolation to people testing positive and their contacts. More information is provided on this in Chapter 6 and Chapter 7 of the Technical Report on the COVID-19 pandemic in the UK (**CW14/150 – INQ000203933**).

160. Baroness Harding reported directly to the Prime Minister and Cabinet Secretary and was directly responsible to them (this would later transfer to the Department on 3 December 2020) (**CW14/22 - INQ000107093**). Ministerial accountability for testing and NHS Test and Trace remained at all times with the Secretary of State for Health and Social Care. Baroness Harding was able to shape NHS Test and Trace as required

bringing in external experts along with utilising resource from across government. This saw members of staff from the Department, along with military personnel, being seconded into NHS Test and Trace and members of her team operating from the Department's offices in London, broadening an approach which began prior to the formation of NHS Test and Trace. Baroness Harding worked very closely with the Department, frequently working from 39 Victoria Street, and made a point of discussing what NHS Test and Trace was doing with the Department. My view is that Baroness Harding did an exceptional job in extremely challenging circumstances, and frequently received unfair criticism of her role.

161. As I have stated above, David Williams agreed to act as an Additional Accounting Officer for the Department and was the responsible Accounting Officer for Test and Trace. David Williams therefore oversaw the financial management and governance of the Test and Trace programme, while day to day financial management and planning activity was undertaken by staff seconded into the Test and Trace team.

Testing capacity and prioritisation policy: March - July 2020

162. In mid-March, testing capacity had reached circa 5,000 per day, but was being exceeded by demand. PHE developed clinically agreed priorities for testing capacity on 11 March 2020. This guidance had been reviewed by the DCMO (Jonathan Vam Tam), PHE Medical Director, PHE NIS Director, NHS Medical Director, and NHS England Strategic Incident Director. I was not directly involved in the development of this guidance, but I was aware of its substance. It was agreed that, given the current constraints within capacity, PHE should publish the top three priorities, but the full guidance was as follows:
    a. Group 1 (test first): Patients requiring critical care for the management of pneumonia, Acute Respiratory Distress Syndrome (ARDS), or influenza like illness (Ill), or an alternative indication of severe illness;
    b. Group 2: All other patients requiring admission to hospital for management of pneumonia, ARDS or Ill;
    c. Group 3: Clusters of disease in residential or care settings, e.g. long-term care facilities, prisons or boarding schools;
    d. Group 4: Community patients meeting the case definition (over 60 years or risk factors for severe disease) and not requiring admission to hospital with prioritisation given to age;
    e. Group 5: Community patients meeting the case definition (under 60 years with no risk factors for complication) and not requiring admission to hospital; and

f. Group 6 (test last): Contacts of cases.

163. Having increased capacity to 10,000 tests on 23 March and 15,000 on 1 April, on 2 April 2020 the Government announced a wider testing strategy based on the establishment of five testing 'pillars' (**CW14/151 - INQ000106460**). The five pillars of the strategy were:

a. Pillar 1: Scaling up NHS swab testing (utilising PHE and NHS laboratories);
b. Pillar 2: Mass-swab testing for critical key workers in the NHS, social care and other sectors (working in partnership with universities, research institutes and companies to create a mass testing infrastructure in the UK through the creation of a network of new laboratory and testing sites across the UK);
c. Pillar 3: Mass-antibody testing to help determine if people have immunity to COVID-19;
d. Pillar 4: Surveillance testing to learn more about the disease and help develop new tests and treatments; and
e. Pillar 5: Spearheading a Diagnostic National Effort to build a mass-testing capacity at a completely new scale.

164. The strategy set out an ambition to reach 100,000 tests across the 5 pillars by 30 April 2020. A further ambition was set to achieve capacity for 200,000 tests by 31 May 2020. The increased capacity of testing enabled health and care staff to continue working, led to a much greater understanding of how and where the virus was spreading, and helped enable some NPIs to be scaled back. Testing capacity was one of five tests that were used to decide whether to proceed in loosening the NPIs.

165. The following table sets out how testing capacity was prioritised as capacity increased throughout the period:

Date	Daily testing capacity	Groups added to eligibility
14 March 2020	Approximately 3,000	Testing of patients requiring critical care for the management of pneumonia, ARDS or influenza like illness (ILI), or an alternative indication of severe illness had been provided e.g. severe pneumonia or ARDS.

		All other patients requiring admission to hospital or management of pneumonia, ARDS, or ILI. Clusters of disease in residential or care settings e.g. long-term care facility, prisons, boarding schools. Where clusters arose, following 5 positive tests, any new symptomatic cases were assumed to be positive without conducting testing.
27 March 2020	10,949	NHS staff with symptoms and their symptomatic families.
12 April 2020	27,947	Symptomatic NHS non-frontline staff and their symptomatic household members.
15 April 2020	38,766	People being discharged from hospital to a care home, whether or not symptomatic. Testing of all symptomatic care home residents (expansion from first 5 members of a cluster). Testing of all symptomatic staff in care homes and symptomatic members of their household (expansion from first 5 members of a cluster).
24 April 2020	49,862	Symptomatic essential workers and their symptomatic family members.
27 April 2020	73,400	All emergency admissions to hospital.
28 April 2020	77,365	Asymptomatic staff and residents of CQC registered care homes whose primary demographic is residents -over 65 or those with dementia. Anyone symptomatic over 65, as well as symptomatic members of their households.

		Symptomatic workers who were unable to work from home.
18 May 2020	127,697	Anyone symptomatic across the population.
30 May 2020	205,634	Antibody testing launched for health and social care staff fin England.
07 June 2020	186,455	Asymptomatic staff and residents of all. remaining CQC registered care homes for adults.
10 June 2020	229,704	Asymptomatic staff in high contact professions, like taxi driver.
06 July 2020	349,109	Regular retesting of care home staff (weekly) and residents (monthly).
13 July 2020	339,755	Outbreak testing guidance amended to include rapid response testing.

Testing in Adult Social Care

166. As testing capacity increased, adult social care was a particular priority. With testing capacity having reached over 35,000, on 15th April 2020 the Adult Social Care Plan set the requirement for all patients to be tested prior to discharge to a care home (**CW14/152 - INQ000107086**). The guidance made it clear that:

a. All individuals must be tested, and should receive their result, prior to discharge from hospital to a care home. Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be;

b. For people who were asymptomatic and discharged into a care home, these individuals would have been tested prior to admission to the care home. Again, where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be;

c. Where the pre-admission test was negative, the guidance still recommended isolation for 14 days;

d. For individuals coming from the community, move to these residents being tested prior to admission; and

e. If the appropriate isolated care is not available with a local care provider, the individual's local authority will be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period.

167. It was announced on 28 April 2020 that the Department intended to ensure whole-home testing of all staff and residents in care homes for older people (those over 65) (**CW14/153 - INQ000106391**; **CW14/154 - INQ000106463**). On 7 June, it was announced that this had been achieved for all care homes for older people and those with dementia.

168. As set out in Chapter 8.2 of the Technical Report on the COVID-19 pandemic in the UK (**CW14/150 – INQ000203933**), epidemiological and genetic evidence from across the UK suggests that although some care home outbreaks of COVID-19 were introduced or intensified by discharges from hospital into care homes, hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes. Prior to testing being widely available, the risk of keeping care home residents in hospital at a time of rapidly increasing nosocomial infection risk needed to be balanced with the risk that they might already have acquired COVID-19 and introduce it to the care home.

Models for distribution and uptake of testing from September - December 2020

169. In September 2020 laboratory capacity was exceeded by demand for a two-week period that coincided with the return of children to school.

170. A number of new models for distributing and encouraging uptake and reporting of test results were trialled from September 2020 to December 2020, including increased access to testing and testing infrastructure by Local Directors of Public Health through the Community Testing Programme, mass testing exercises in specific locations e.g., city-wide testing in November 2020 and testing trials in specific workplaces and settings. This work informed the further expansion and rollout of testing from January 2021. This approach to mass testing using lateral flow tests (LFTs) was characterised in the media at the time as the Moonshot Programme.

171. Trials in the mass testing programme included:
    a. City-wide testing in Liverpool in November 2020 to detect as many positive individuals as possible;
    b. Trials in schools and universities in November 2020 to detect asymptomatic cases; and,
    c. Workplace testing trials starting in December 2020 to detect asymptomatic cases and prevent secondary spread.

172. The use of pilots and rapid evaluation enabled lateral flow testing to be rolled out rapidly to support the country in 'living with COVID'. Notably visitors were allowed into Care Homes in December 2020 with the use of LFTs. All secondary schools, colleges and universities used LFTs at the start of January 2021 to test students and teachers and prevent the spread of the virus. Testing eligibility and use expanded over the course of 2021 culminating in the 'universal offer' of testing to everyone in the country in April 2021. As I have described above, responsibility for procurement and distribution – so far as within DHSC's remit and including in relation to PCR testing equipment and LFTs – lay with the DHSC Second Permanent Secretary, David Williams, and with Jonathan Marron, for procurement and distribution respectively.

173. In respect of issues with procurement and distribution of PCR testing equipment and LFTs, so far as it relates to PHE, I would adopt the position as set out by David Williams in his statement to Module 2 of this Inquiry (**CW14/155 - INQ000279950**), at paragraph 70-72. I repeat this as below:

70. 'In my view, PHE are outstanding public health experts but were not scaled for activity on the level demanded by pandemic. PHE provided initial tracing support but were quickly swamped by the scale of tracing required. There was a clear boundary with the Department, but the Department had to step in as delivery challenges became apparent. PHE's relationship with NHS England was less consistent, for example in early testing ramp up to an initial 10,000 tests, where each organisation was essentially pursuing its own route to expansion of capacity rather than acting in a co-ordinated way.

71. The medical and scientific expertise at the core of PHE was first class, and informed the development of NHS Test & Trace.

72. My personal observation is that I expected PHE to be more proactively joined up with Local Authority public health counterparts. There were early concerns from Local Authority Directors of Public Health about engagement, and what would be done at a national versus a local level. These were issues I expected PHE to manage. For example, in April 2020, I was involved in engagement with the President of the Directors of Public Health and with a broader group of these Directors, facilitated by Professor Chris Whitty, as the Department sought to design the testing and contact tracing programme which became NHS Test & Trace

(DW/24 - INQ000273574). This local dimension became central to the direction and operation of NHS Test & Trace, both with secondment by Dido Harding of a Local Authority Chief Executive on to her executive team and through the local focus of the work of the Joint Biosecurity Centre.'

Medical equipment – including ventilators

DHSC's approach to ventilators

174. In the early stages of the pandemic the NHS believed it may require far more mechanical ventilators than were available. By the beginning of March 2020, modelling based on RWCS planning assumptions and assured by SAGE indicated that up to 90,000 adult beds with ventilators may be needed to care for COVID-19 patients. The Government's strategy was to rapidly increase UK ventilation capacity by acquiring as many ventilators as possible from both UK and global suppliers. In the early stages of the pandemic the focus was on ICU capabilities and rapidly purchasing equipment and upgrading infrastructure to ensure there was enough capacity in the system to meet the immediate need.

175. In response to the immediate need for more mechanical ventilators, the Government developed a cross-departmental approach across the following three workstreams:
    a. increased purchasing of existing ventilators available to the NHS (this was led by the Department/NHSEI under the National Covid Oxygen, Ventilation, Medical Devices & Clinical Consumables (O2VMD&CC) Programme) (**CW14/156 - INQ000106555**);
    b. ramping up the manufacture of existing ventilator designs (led by Cabinet Office); and
    c. partnering designers with large manufacturers to rapidly develop and manufacture new simplified ventilator designs (led by Cabinet Office).

176. While the NHS was responsible for procuring medical equipment including oxygen and ventilators before the pandemic, it became clear that this system, which gave the NHS the choice to use the NHS Supply chain to procure medical equipment such as ventilators, would not meet anticipated ventilator demand. In summary of the UK's ventilator capacity from March to August 2020, in March 2020, the NHS had around 7,400 mechanical ventilators. Modelling based on the trajectory of other European countries forecast the need for significant and extremely rapid increases in the UK ventilator

capacity and the Government adopted a formal target to secure up to 30,000 ventilators by 30 June 2020.

177. Workstream a, the O2VMD&CC Programme, was therefore introduced on 3 March 2020 as a collaborative programme between the Department and NHSE/I, which became the primary programme through which the Department procured ventilators on behalf of the NHS. Respective roles within the programme were split between these two organisations and a governance structure was introduced to reflect this.

178. Workstream a. is separate and distinct from workstreams b. and c. The Department and the Cabinet Office ran their programmes separately but worked towards the same overall targets and exchanged data on their progress in acquiring ventilators daily. I was not involved in procurements of ventilators completed within the O2VMD&CC Programme as I was not the DHSC's responsible Accounting Officer in relation to procurement of ventilators; that responsibility fell to David Williams. I was not involved in individual decisions to procure ventilators, as I have described above at paragraph 46. As workstreams b. and c. were led by Cabinet Office, procurement decisions under those programmes were not overseen by DHSC, and so no DHSC Accounting Officer was responsible for procurements made under those workstreams.

179. Workstreams b. and c. detailed above became known as the 'Ventilator Challenge', which was a Cabinet Office-led programme to encourage domestic suppliers to manufacture ventilators. (**CW14/156 - INQ000106555; CW14/157 – INQ000106203; CW14/158 – INQ000106234; CW14/159 - INQ000106519**). The Department and the Cabinet Office ran their programmes separately, but worked towards the same overall targets and exchanged data on their progress in acquiring ventilators daily.

180. The Ventilator Challenge began on Friday 13 March 2020 with Cabinet Office inviting a number of organisations to take part in the project, followed by a "call to arms" to industry bodies by the Prime Minister on 16 March 2020. By 30 April 2020, the total number of ventilators available to the NHS had increased to 11,500 and by 30 June 2020 it stood at around 24,000 (of which around 12,000 had been built via the Ventilator Challenge). The Department and Cabinet Office met the 30,000 target in early August 2020.

181. During this period, the anticipated demand for ventilators in the NHS did not materialise and, although the 30,000 target was not met until August 2020, the Department and

NHSE/I are not aware of any UK patient being unable to access a ventilator when needed.

182. Following the subsidence of the initial surge of COVID-19, the Department's policy decisions in connection with the Ventilator Programme sought to control the spread of the virus, whilst also developing policy aimed at moving towards business as usual.

183. The Ventilator Programme realigned with the Government's COVID-19 Recovery Strategy, NHS and Care Capacity, and Operating Model to maximise confidence in managing new cases. In particular, renewed focus was placed on preparation for a potential winter 2020/21 surge in COVID-19 cases.

184. The Ventilator and the Ventilator Challenge Programme continued to manage the deployment of ventilators and associated equipment across health and care, including ongoing logistics and handling requirements, appropriate storage, testing, and asset management. The summer period in 2020 afforded time and space to address the potential capacity requirements and demands associated with subsequent surges of COVID-19. Consideration was also given to the longer-term management of equipment assets and the robustness of ventilator consumables availability, ensuring everything required was available at the right time and place and in the right quantity.

185. During the second wave in early 2022, the focus was on identifying opportunities to improve long-term resilience within the ICU Consumable supply chain. This was aligned with the broader, whole of government Battle Plan. Whilst the immediate work of securing NHS supply through stockpiling was taking place, focus was also on the below:

Phase Two Workstream	**Phase Two Objective**
Oxygen Production & Distribution and Pipework	Enable existing contingency measures to be quickly ramped back up as needed.
Ventilation and Equipment	Put in place a strategic equipment management process.
Clinical Consumables	Create a formal stockpile of consumables for use in future surges and broader supply disruption events.
Logistics and Warehouse Operations	Manage transition into medium and long-term storage and distribution.

Programme Core	Provide Project Management Office (PMO) support to the programme.
Future Data	Future data programme and a new organisation design activity.
Global Supply Risks	The Global Supply Risks workstream did not take place due to lack of funding availability.

186. Ventilation and Equipment objectives were to put in place a strategic equipment management process. Phase 2 which ran from June 2020 to December 2020, started in a significantly improved position from Phase 1 which ran from March 2020 to May 2020, as significantly enhanced quantities of devices were available. Key activities included:

a. Managing strategic deployment of scarce equipment across the NHS estate, including strategic reserve;
b. Equipment operations together with handling ongoing allocations, asset management, and distribution issues;
c. Taking receipt of the ventilator challenge devices, ensuring that the programme closed;
d. Managing the deployment of assets to maximise quality, strategic fit;
e. Creating a strategic reserve of devices for use as part of any future response;
f. Ongoing contract management activities to ensure receipt of remaining devices ordered as part of Phase 1; and
g. Planning was also undertaken for strategic allocation of devices for winter and handling surplus (donation/ sale) stock.

187. With respect to overall government spend arising from the procurement of ventilators throughout the COVID-19 pandemic, I repeat the following from the Department's corporate witness statement for Module 3 (**CW14/160 - INQ000389241**):

105. "Although there is no evidence of substantial issues that were reported to the Department in relation to the availability of ventilators specifically, there was a National Audit Office report into both the CO and Department's ventilator programmes that looked at whether the urgent need for ventilators ever materialised, and if the Government, therefore, overspent on ventilators that were not needed. It concluded that the urgent need did not materialise and the overall costs of both programmes were higher than would be expected in normal times. However, it recognised that both departments maintained sufficient records of their programmes' rationale, the key spending decisions they took and the information

they had to base those on. It also concluded that the departments had put in place effective programme management, controlled costs where they could and recovered some of their committed spending once it became apparent that fewer ventilators were needed than they had originally believed" (**CW14/156 - INQ000106555**).

188. As noted above, I had regular meetings with my counterparts in the Devolved Administrations (DAs). On 27 March 2020, I met with my DA counterparts to discuss concern over equity of supply. The readout from the meeting shows that my DA counterparts raised two issues **(CW14/23 – INQ000496795)**.

189. The first issue related to whether suppliers were being told directly that they should liaise solely with NHSE on UK supply rather than with DA specific systems. My DA counterparts suggested this would cause potential relationship issues should it be found to be taking place. While it was confirmed in this instance that was not the case when the concern was raised, I asked my DA counterparts to escalate future specific concerns to me, for them to be considered on a case-by-case basis.

190. The second related to concern that supplies of PPE would be diverted to areas where there were immediate outbreaks of COVID-19 in the south of England, and this would deplete PPE and ventilator stocks available for use by the DAs. I suggested that DAs could share their modelling so administrations could work closely together to ensure a joined-up approach.

191. On 16 April 2020, I wrote to the Permanent Secretaries of the DAs after a meeting on 9 April about international procurement efforts. I set out that the UK Embassies were instructed to work on a single UK 'ask' on international procurement which would include the needs of Scotland, Wales and Northern Ireland, and that the Joint Action and Coordination Team (JACT) (comprised of both DIT and FCO) and overseas network, had been advised to undertake no new procurement 'asks' but stood ready to support future orders. I stated that it would be "the best way to obtain a supply of goods that can support the needs of the whole of the UK". To ensure this would be a successful approach, the letter asked for DAs to continue to share their stock positions so that the JACT and overseas network could target their procurement efforts to best effect (**CW14/161 - INQ000496822**).

192. My attention has also been drawn to the fact that I was involved, along with other officials, in a mutual aid deep dive on 12 November 2020 (**CW14/162 - INQ000562467; CW14/163 - INQ000562466**). I do not remember anything about this save that I attended this meeting.

Coordination of policy during the pandemic

193. I have been asked about my role in co-ordinating this approach with other policies. Of course, as the knowledge of COVID-19 developed, the need for procurement of particular vaccines, therapeutics, tests or others changed or increased. I have no particular comments to make about this.

Lessons Learned

194. The Department has identified five themes which have acted as a framework for its reflections and to aid its lessons learnt. These were detailed in my third witness statement for Module 3, on behalf of the Department (**CW14/164 - INQ000473872**), and further discussed in the Department's closing statement for Module 1 (**CW14/165 - INQ000235083**).

195. I reproduce those themes as stated in my Module 1 closing statement below (with emphasis added), and make additional reflections of relevance to this Module:

a. **Creation of a "tool kit" of capabilities which can adapt to deal with whatever public health risk emerges, rather than a fixed plan against specific threats or viruses.** The evidence from module one was clear that, given the unpredictability and range of possible future pandemics, it is unrealistic to try to create a specific plan for each possible new threat. Instead, the Department recognises the need for future pandemic preparations to focus upon developing a "toolkit" of capabilities which can flexibly pivot to address different emerging threats and are backed up by sufficient resources so that they can be "scaled up" quickly. Such resources include having global communication and data systems to identify emerging High Consequences Infectious Diseases ("HCIDs") with rapidity, testing capacity which can be increased rapidly to identify the spread of the pathogen on a wide basis, if needed, and sufficient stockpiles of medical countermeasures which can be distributed across the UK.

b. In the context of the procurement and distribution of key healthcare equipment and supplies, such a toolkit must encompass: i) a sufficient stockpile, ii) a robust manufacturing base (with no suggestion that this must be entirely onshore) accessible and distributable through efficient, resilient and transparent supply networks, and iii) effective purchasing frameworks.

c. **Resilience matters**. High resilience means the supply and distribution system will be more likely to respond to shocks of any kind when they occur.

d. The system must be ready ensure essential medical equipment and supplies, including PPE, medical equipment, and other necessary equipment, can be obtained and distributed to meet the level of demand created by a future pandemic. It must be considered whether this is through domestic manufacture or sourcing from trusted supply networks and distributed across robust logistic systems to meet demand generated by any future pandemic. A resilient supply system must encompass:
   i. maintaining a trusted (but not necessarily entirely domestic) manufacturing base;
   ii. ensuring supply chains, including the NHS Supply Chain in particular as the peace time approach to purchase and distribution of supplies to the NHS, are resilient and transparent; and
   iii. maintaining the underlying financial capacity across system actors to meet market prices for necessary equipment, accounting for the market realities including, as is the case currently, raw material inputs' heavy concentration in East Asia.

e. **There must be the ability to "scale up" quickly.** The Department has reflected that a key lesson learnt from the pandemic is the need for plans and the ability to scale up staffing and equipment necessary to address and mitigate the spread of a disease quickly assuming that it will impact all of society.

f. Goods and equipment must be ready to be used and plans in place as to how they may be scaled up quickly. As stated in the Department's written closing statement to Module 1, "the extent of any latent surge capacity can only be determined after society asks itself what proportion of resources we are willing to invest in "insurance" against a future pandemic. To answer this question, technical advisers need to be explicit with political leaders about how much varying levels of insurance will cost to

reduce the impact of a pandemic by varying amounts, and in turn political leaders need to be transparent with society about the choice between having insurance against future events and investing in immediate pressures and emergencies…The Department's view is that to make that decision easier, investment in scaled up capacity should, where possible and relevant, be used in non-pandemic periods and be helpful in addressing multiple potential risks."

196. **Use diagnostics and data**. Data tracking of the type used in PPE distribution was crucial. The importance of diagnostics and Test and Trace have been discussed elsewhere. See, for example: (**CW14/166 - INQ000551566)**.

197. **Prepare for future threats, not just for COVID-19**. Pandemic preparedness should not seek to prepare for the pandemic which has just happened; instead, pandemic plans need to take account of and be responsive to all the modes of transmission of communicable disease pandemic or major epidemics which could in the future occur, namely respiratory, touch, oral, blood and vector.

198. In any situation where there is a shortage of a vital good, government faces a binary yes or no choice: buy at the available price or go without. There is no further alternative of buying cheaper. The Government took the view that the public interest was better served by buying at a price available as opposed to the country running out. This was, in my view, the correct decision.

199. A number of external reports have been produced which are relevant to procurement and distribution, which provide recommendations and advise lessons to be learned for DHSC and across government from the pandemic period. I made reference to many of the below reports in my twelfth witness statement to the Inquiry provided for Module 3 (**CW14/164 - INQ000473872)**. I agree with the recommendations made therein.

National Audit Office report: Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19

200. On 30 September 2020, the NAO published a report entitled 'Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19' **(CW14/167 - INQ000087456).**

Public Accounts Committee (PAC) report: COVID-19: Supply of ventilators

201. On 25 November 2020, the PAC published a report entitled 'COVID-19: Supply of Ventilators' **(CW14/168 - INQ000087194).**

National Audit Office report: The supply of personal protective equipment (PPE) during the COVID-19 pandemic

202. On 25 November 2020, the NAO published a report entitled 'The supply of personal protective equipment (PPE) during the COVID-19 pandemic' **(CW14/169 - INQ000145895).**

Public Accounts Committee report: COVID-19: Government procurement and supply of Personal Protective Equipment

203. On 10 February 2021, the PAC published a report entitled 'COVID-19: Government procurement and supply of Personal Protective Equipment' **(CW14/170 - INQ000145899).**

National Audit Office report: Initial learning from the government's response to the COVID-19 Pandemic

204. On 19 May 2021, the NAO published a report entitled 'Initial learning from the government's response to the COVID-19 pandemic' **(CW14/171 - INQ000128524).**

Public Accounts Committee report: Initial lessons from the government's response to the COVID-19 pandemic

205. On 25 July 2021 the PAC published a report entitled 'Initial lessons from the government's response to the COVID-19 pandemic' **(CW14/172 - INQ000087199).**

206. In the months following the Government response, I sent the PAC a series of letters updating on various matters arising out of recommendations in the PAC's report. In summary:

a. On 30 November 2021, I wrote to the PAC providing data relating to PPE, as requested by the PAC in the first recommendation set out above **(CW14/173 INQ000075342.**

b. On 2 March 2022, I wrote to the PAC to provide the second quarterly update on data concerning PPE **(CW14/174 - INQ000469746).**

c. On 14 June 2022, I wrote to the PAC to provide the third quarterly update on data concerning PPE **(CW14/175 - INQ000469750).**

d. On 1 November 2022, I wrote to the PAC to provide the fourth quarterly update on data concerning PPE **(CW14/176 - INQ000469754).**

e. On 16 March 2023, I wrote to the PAC to provide the fifth quarterly update on data concerning PPE **(CW14/177 - INQ000471096).**

f. On 30 March 2023, I wrote to the PAC providing a small point of clarification in relation to the letter that I sent to the PAC on 16 March 2023, setting out the Department's fifth quarterly PPE update **(CW14/178 - INQ000469756).**

g. On 21 June 2023, I wrote to the PAC to provide the sixth quarterly update on data concerning PPE **(CW14/179 - INQ000339320).**

h. On 7 November 2023, I wrote to the PAC to provide the seventh quarterly update on data concerning PPE **(CW14/180 - INQ000371236).**

Statement of Truth

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

Signed: Name Redacted

Dated: 5 February 2025