Witness Name: Major General Phillip Prosser

Statement Number: 1

Exhibits: 16

Dated: 21 January 2025

IN THE MATTER OF THE COVID INQUIRY

FIRST WITNESS STATEMENT OF

MAJOR GENERAL PHILLIP PROSSER

I, Major General Phillip Prosser, of Defence Support, Strategic Command, Ministry of Defence, Abbey Wood, Bristol, BS34 8JH, will say as follows –

A. Introduction

1. I am Major General Phillip Prosser. During the Covid-19 pandemic (the "**pandemic**"), whilst holding the rank of Brigadier Commander of the 101 Logistic Brigade, I was deployed to the personal protective equipment ("**PPE**") Team within NHS England ("**NHSE**") headquarters to assist NHSE in the distribution of healthcare equipment from 19 March 2020 to 23 July 2020.

2. This statement has been prepared at the request of the UK Covid-19 Inquiry (the "**Inquiry**") dated 10 October 2024 bearing the reference M5/PROSSER/01 in relation to Module 5: Procurement (the "**Module 5 Request**"). It has been produced with the assistance of individuals within the Ministry of Defence (the "**MOD**" or the "**Department**") with specific knowledge of areas covered by the Module 5 Request and legal advisors and draws from a range of documents which are exhibited.

3. On 12 April 2023, the MOD provided a witness statement from Mr David Peter Williams addressing Module 1: Resilience and preparedness (the "**Module 1 Statement**"). In addition, on 6 September 2024 and 27 September 2024 the MOD provided two further witness statements from Dr Jill Hatcher addressing Module 5 (together the "**Module 5 Statements**"). I have been provided with copies of these statements and reviewed them for the purposes of preparing this witness statement. To the extent that the contents of those statements are within my own knowledge I agree with them and matters addressed in those statements are not repeated here but are referred to where relevant.

4. This statement is structured as follows:

    a. Section B: Background.

    b. Section C: My Role in NHSE.

    c. Section D: Issues relating to the gathering of data on PPE procurement and distribution.

    d. Section E: Lessons learned and reflections on procurement and distribution processes.

B. Background

5. In broad terms, my background is in engineering and logistics.[1] At the time of the pandemic, I had served in the Armed Forces for 28 years, including in Kosovo, Iraq and Afghanistan on three separate occasions. On each of those deployments, I led teams in crisis conditions and made decisions in relation to engineering and logistics matters. I set out below my experience immediately prior to, during, and after the pandemic.

6. From September 2016 to July 2019 I was employed as Team Leader of the Operational Support Vehicle Portfolio in Defence Equipment and Support ("**DE&S**"). I was responsible for managing the In-Service Support to over 45,000 military wheeled vehicles, including managing their support solutions provided by Industry, and overseeing the procurement of spares. During this role, I was detached from 4 January 2018 to 27 April 2018 to attend the Higher Command and Staff Course at the Defence Academy in Shrivenham. The purpose of that course is to "*prepare future strategic*

[1] **[PP/01 - INQ000561734]**

leaders for higher command appointments across defence and the security environment".[2] On completion of that course I returned to my role at DE&S.

7. From 26 July 2019 to May 2021, I commanded 101 Logistic Brigade ("**101 Brigade**"), which provided command and control to the 17 Combat Service Support units in 3rd (UK) Division, which is the UK's strategic land warfare asset, as well as staff to augment the divisional headquarters.

8. From May 2021 to February 2023, I acted as Assistant Chief of Staff (Equipment) in Headquarters Field Army. In this role, I was responsible for the availability of the Field Army equipment fleet in the short, medium and long term.

9. During the pandemic, I was deployed to NHSE on three occasions:

    a. from 19 March 2020 to 23 July 2020;

    b. from 12 November 2020 to 30 April 2021, in order to assist with the vaccine distribution operation; and

    c. for 5 weeks from December 2021 to January 2022, in order to assist with the vaccine distribution operation as the Omicron variant increased demand for vaccines.

10. I address the first of those occasions below. I do not address the two subsequent occasions, as on those occasions my role was concerned with vaccine distribution, which I understand not to fall within the scope of the Module 5 Request.

11. I am currently employed by Strategic Command as Director Joint Support. In this role I: oversee the Department's ability to deliver a Strategic Base Outload in times of war; act as the Joint User for the Defence Supply Chain; ensure that acquisition programmes have Support Solutions which are capable of integrating into the Defence Supply Chain and are policy compliant; and ensure the design and delivery of the Defence Support digital architecture.

C. My role in NHSE

1. My appointment to NHSE

[2] **[PP/02 - INQ000561735]**

12. The role I played during my deployment to NHSE was set out in the original request by the NHS for MOD Support through the Military Aid to the Civil Authorities ("**MACA**") mechanism. I received this order on the evening of 19 March 2020, before my deployment to NHSE Headquarters in Skipton House, London the following day on Friday 20 March 2020.

13. On that Friday, the Prime Minister addressed the nation in a speech where he told cafés, pubs, bars and restaurants, as well as other leisure facilities, to close, and not to open the next day, and asked people not to go out, to "*stay at home*" to save lives. The following Monday (23 March 2020), the Prime Minister would announce the first national 'lockdown' in his televised address to the nation. I understand that, whilst the UK had PPE stockpiles intended to address emergency situations, those contingency plans did not anticipate the collapse of national and global business-as-usual supply chains, the type or speed of transmission of a coronavirus, nor the impact this could have on the level of demand for PPE. Further, at that time the number of UK infections and deaths from Covid-19 were rapidly increasing, accompanied by intensifying media stories in March about international shortages of protective equipment in health and care settings. I understand that, in the UK, medical staff groups expressed concern that the NHS was struggling to obtain the PPE they needed.[3]

14. That was the context in which NHSE requested my support and in which I undertook the actions set out in this statement, which focuses on the initial phase of the pandemic during which I, and NHSE, faced unprecedented challenges and operated under the most challenging of conditions.

15. In brief, NHSE requested logistics expertise and support for the immediate distribution of PPE across the NHS Estate as demand increased to what I believe to be unprecedented levels over the early days of the pandemic. My responsibilities included the following:

    a. Establishing a joint planning team in Skipton House;

    b. Assessing and quantifying current NHS PPE demand across the national estate including primary care (e.g. GP surgeries), secondary care (e.g. hospitals) and community care (e.g. care homes, palliative care providers, residential care sites). At the time of the request, it was anticipated that my role would include responsibilities in relation to Wales, but in the event that was not

[3] Certain of the matters contained in this paragraph are drawn from the Department for Health and Social Care Module 5 Statement, which the Inquiry granted me permission to read.

the case. I understand that support provided by the MOD to NHS Wales was provided under a separate MACA, although I am not privy to the details of that MACA;

c. Identifying and testing feasibility of options for the consolidation of current stock and depot management;

d. Quantifying storage capability at proposed depot and receiving sites;

e. Producing logistic solutions for PPE distribution to meet immediate priorities (defined as the next 24-26 hours) across the NHS Estate;

f. Producing logistic solutions to meet interim priorities (defines as the next 72 hours) across the NHS Estate; and

g. Undertaking a Lessons Learning exercise with a view to developing a sustainable surge capability for national PPE requirements.[4]

16. The above request from NHSE was motivated by the extreme urgency of the PPE situation at that time. The increasing number of Covid-19 cases in the UK had led to an unparalleled national demand for PPE: this demand was only to increase over the coming days and weeks. NHSE did not have the national planning experience or capability to meet that demand. The existing commercial partners who worked with NHSE on logistics – being the NHS supply chain entity, Supply Chain Coordination Limited ("**SCCL**") and its subcontractor, Unipart – at this point could not meet this increasing demand. Figure 1 provides an overview of the NHS supply chain. There were a number of commercial partners who provided products, which I understand were then provided to and distributed by the logistics operation run by SCCL and Unipart.

Figure 1: Diagram of the NHS supply chain

[4] **[PP/03 - INQ000561727]**

17. At this point in time I understand that NHSE had estimated that the PPE supply chain would be unable to recover sufficiently within 24-72 hours from the time of the request to meet key priorities and maintain essential services. To put that bluntly, unless urgent steps were taken by the Monday there would be insufficient PPE being delivered to front line services, putting NHS staff and patients at risk. Accordingly, MOD assistance was urgently required.

18. As the request was made under the MACA mechanism the principles set out in *Joint Doctrine Publication 02 UK Operations: the Defence Contribution to Resilience* ("**JDP02**")[5] applied. These principles are explained in more detail in the Module 1 Statement. As explained in that statement, the provision of military assistance is governed by four principles whereby MACA can be authorised:

    a. there is a definite need to act and the tasks the armed forces are being asked to perform are clear;

    b. other options, including mutual aid and commercial alternatives, have been discounted; and either

[5] **[PP/04 - INQ000497457]**

c. the civil authority lacks the necessary capability to fulfil the task and it is unreasonable or prohibitively expensive to expect it to develop one; or

d. the civil authority has all or some capability, but it may not be available immediately, or to the required scale, and the urgency of the task requires rapid external support from the MOD.

19. At the point of my deployment to NHSE I was very conscious that, notwithstanding the seriousness of the situation faced by NHSE in the distribution of PPE, the MOD's primary priority in situations such as a pandemic was the continuation of core Defence business. That is, that while the MOD would seek to provide assistance through the MACA process, its priority was to maintain critical military operations.

20. My understanding is that at this stage, MOD assistance was necessary because other options including commercial alternatives had been discounted and, as above, NHSE lacked the necessary capability to fulfil the task. The initial MACA request detailed that "*[c]ommercial solutions have been explored but are unable to deliver in the immediate timeframe*". I understood that this referred to the insufficient planning capability of NHSE's existing supply chain operation (i.e. SCCL and Unipart) to satisfy the increased demand caused by the pandemic. As such, I understood that my logistics and planning expertise would be used to augment the capacity of the existing supply chain operation.

21. After I received my initial orders, I was copied into an email chain in which there were references to the MOD providing 25 trucks for the delivery of PPE and to the MOD "*establish[ing] a full end-to-end supply chain*".[6] Shortly after I received this email, I had an oral discussion about my deployment, in which neither of these points were mentioned and I was instead told that I was to go to Skipton House and figure out what needed to be done myself. I believe that call was either with Brigadier Charles Ginn, who wrote the email I refer to above, or with **Chief of Staff** my Chief of Staff. As such, I did not place weight on the matters referred to in that email; I took it as an email which was written in the confusion of the moment which had been superseded by my updated instructions. Indeed, that assessment was borne out, as upon my arrival at Skipton House neither of those matters were identified as being the reason for my deployment. Regarding the provision of trucks, once I was at Skipton House it was clear that the 25 trucks mentioned in the email were not required: a lack of trucks was not the cause of the supply chain issues, and, as I explain further below,

[PP/08 - INQ000534264]

there were commercial options available that could provide supply chain support at short notice. However, my recollection is that MOD provided two trucks for an emergency delivery that week, which was reported in newspapers. Regarding the MOD establishing a full end-to-end supply chain, at Skipton House that was not mentioned to me save that, as I discuss further below, Jin Sahota of SCCL suggested that the MOD establish a parallel supply chain, but in my view that was his own idea rather than one discussed with NHSE, the MOD, or other stakeholders.

22. I was initially deployed to NHSE for three weeks. However, my deployment was later extended to four months[7].

23. I believe that I was well-suited for the above deployment for the following reasons:

    a. **First,** I had substantial experience relating to supply chain management and logistics and distribution matters including as follows:

        i. During my role as Team Leader of the Operational Support Vehicle Portfolio at DE&S I worked closely with supply chain specialists on matters across the supply chain including inventory management and supply chain optimisation matters including in relation to warehousing and distribution performance.

        ii. During my role as commander of 101 Brigade, I worked to establish distribution and storage sites to support 3rd (UK) Division in times of war. I had deployed numerous times as part of these operations and attended many study days. In my view, I had substantially more logistics-focused experience than many of my peers.

    b. **Secondly**, I had some experience on manufacturing-related matters. During my role as Team Leader of the Operational Support Vehicle Portfolio, I would occasionally be required to use my engineering judgment to inform engineering solutions to operational problems on the vehicles within my portfolio. I also had some exposure to the issues and challenges of scaling up engineering and manufacturing capacity through undertaking study days on the challenges of major warfare.

    c. **Thirdly**, my background providing logistical and engineering support in extreme environments – including Kosovo, Iraq and Afghanistan as I mentioned

[7] **[PP/05 - INQ000561736]**

above – provided me with an appropriate skillset to meet the unprecedented challenges facing NHSE and the UK at that time.

d. **Fourthly**, my work in DE&S had given me substantial experience of working with Industry partners through commercial relationships. I believe that I had more experience in this area than many of my peers.

e. **Fifthly**, I had substantial experience working with civil servant teams through my work in DE&S.

24. I had had relatively little experience in public sector procurement matters at the time of my initial deployment to NHSE (although I did have some experience working with supply chain experts and commercial staff in my role in the Operational Support Vehicle Portfolio at DE&S described above). However, the support requested by NHSE was distribution and logistical support, rather than support in procurement matters. As such, my role primarily focused on logistics and to the extent that I engaged with procurement-related matters at NHSE, my role was coordinating the activities involved in healthcare equipment procurement, rather than being involved in any procurement work directly.

2. My work at NHSE

25. In broad terms, my role at Skipton House was akin to a Chief of Staff or Chief Operating Officer. I was responsible for running the mechanics of the operation and ensuring that relevant information was presented to the appropriate Senior Responsible Officers ("**SROs**")[8] for decision-making, or escalating information in the case of urgent requirements. I understood my role to be solely acting in a supporting capacity to those SROs.

26. For the avoidance of doubt, I would like to make clear that my role was on the operational side of the PPE Team, and not the commercial side. I was not responsible for the procurement of PPE, and I did not have any involvement in the procurement of PPE with the Buy Team or the MOD personnel seconded to the Buy Team. I did interact with the Buy Team insofar as I integrated them into daily meetings in order to ensure that the relevant decision makers (on both the operational and commercial sides of the process) had a holistic understanding of the supply chain. However, my role was solely

[8] The SRO was initially Emily Lawson, although she was later joined by Jonathon Marron and Lord Paul Deighton.

to facilitate information flow and I had no involvement in any decisions taken by the Buy Team. I address these matters further below.

27. In the following section of my statement, I address my work in the PPE Team under three main headings: unblocking the existing supply chain; the parallel supply chain; and my involvement in decision-making processes. I then address a number of ancillary matters.

i. Unblocking the existing supply chain

28. Upon my deployment to NHSE on 20 March 2020, my first concern was to understand the totality of the challenge.[9] NHSE had indicated concern that it had insufficient capacity to outload the PPE which it already had in stock quickly enough to keep up with demand. The NHS had been ordering significantly increased quantities of PPE. However, the extant regional distribution centres were not designed to delivery this unprecedented quantity of supplies, and circa 30% of the workforce was absent (either because they had Covid-19 or were 'shielding') at that time. As such, the PPE distribution network was, to put it colloquially, 'jammed'. Whilst the PPE distribution network was jammed, that is not to say that this was due to any flaw or defect in its design; PPE demand was between eight and 20 times greater than usual and therefore significantly exceeded the planning assumptions for the SCCL-delivered network. Nonetheless, I regarded resolution of the network jam issue as an urgent priority.

29. Over 20-21 March 2022 my staff and I designed a plan that Standing Joint Command ("**SJC**") Headquarters would deploy 312 personnel over 2 weeks to multiple distribution centres to assist with the outload[10]. I recall that, having devised this plan, it was formally agreed by Emily Lawson of NHSE before being put into effect through a MACA. This intervention proved effective in unjamming the system; I understand that the majority of personnel who were deployed fulfilled their task of assisting the initial outload within a period of 12-20 days.[11]

ii. The parallel supply chain

[9] This approach was in accordance with UK MOD Doctrine namely UK Ops and Resilience: 20200320 UK Resiliance doctrine. [PP/06 - INQ000561728]
[10] [PP/07 - INQ000561733]
[11] [PP/07 - INQ000561733]

30. As I explain above, I was deployed to NHSE on Friday 20 March 2020. During the initial part of my deployment I helped to create a more resilient and agile PPE distribution system through assisting NHSE establish an additional supply chain with sufficient capacity to meet the distribution challenge.

31. As explained below, SCCL, NHSE's existing commercial partner, lacked confidence in its ability to deliver PPE where it was required through the existing supply chain. This is unsurprising in circumstances where the existing NHS supply chain for PPE in England was designed to accommodate delivery to 226 NHS Trusts; but NHSE was now required to deliver PPE to some 58,000 different settings including care homes, hospices, primary care providers such as GPs, community care organisations, coastguards, and prisons. I understand that the number of settings for which NHSE was responsible increased over the latter part of March to reach the 58,000 settings I referred to above.

32. On Saturday 21 March, my team[12] and I attended a briefing by Mr Sahota, the CEO of SCCL. This was an in person briefing and to my knowledge no notes were taken. I have what I believe to be a clear recollection of the briefing, because it was at such an early stage of my deployment, the information he conveyed was significant at the time, and I was required to act on it urgently. During the briefing my recollection is that Mr Sahota informed us that the present system – under which SCCL had contracted with Unipart, a logistics company, to provide warehousing and distribution services to the 226 NHS Trusts – was incapable of meeting the distribution challenge facing it. I recall being informed during this briefing that the information systems utilised by the existing supply chain were incapable of handling any more procurement contracts, that the distribution systems were operating at capacity, and that there was no unified portal for ordering which could handle the increased orders from NHS Trusts and, over time, the requests from the 58,000 settings for which NHSE was now responsible. It is my understanding that against this backdrop Mr Sahota had imposed demand management restrictions on NHS Trusts to avoid PPE over-ordering. I consider that to be an extreme step demonstrating significant supply chain disruption. Having explained this, he made it clear to me that he was of the view that, in short, the MOD would have to step in and solve the problem.

33. It did not seem to me at that time that Mr Sahota had in mind any particular mechanism by which the MOD should provide the necessary distribution service. He did not elaborate on 'how' this issue was to be resolved, only that his view was that the MOD

[12] Chief of Staff, Name Redacted

needed to solve the problem because he was unable to do so. He did not say that the proposal of the MOD solving the problem was a position which he had agreed or discussed with anyone in NHSE, the MOD, or other stakeholders. My impression is that this was an idea that he had come up with himself and proposed in the moment.

34. I do not recall much further discussion during that briefing and I left without a clear view as to next steps; I knew only that I had been tasked with identifying and potentially implementing a solution to a pressing and urgent situation. This new request was not within what I understood to be the scope of the MACA assistance which I had been deployed to provide. I had been deployed to provide planning support to the existing supply chain, rather than establishing a new, bespoke, end-to-end supply chain. However, in view of the urgency of the situation, and the limited options that were apparently available, I was determined to assist if it was possible for me to do so.

35. I first considered whether the MOD itself could provide the necessary supply chain. However, this was not an obviously viable option, for the following reasons:

    a. **First**, in accordance with the principles set out in JDP02, the MOD should only provide MACA support where there is no other available option. The task before me was for the provision of warehousing and distribution services, which in my view were tasks which could be performed by civilian commercial contractors, as ultimately was the case.

    b. **Secondly**, 101 Brigade's expertise was in deployed logistics (i.e. logistic operations during warfighting), whereas the task facing me was the establishment of a new domestic supply chain. Accordingly, I considered that 101 Brigade, or the MOD, did not have particular expertise which made it more suited to the task than a civilian commercial contractor.

    c. **Thirdly**, the scale of the task was enormous. If the MOD were to be solely responsible for establishing this secondary supply chain, in my view, around 5,000 to 10,000 personnel would have been required to provide support for a potentially indeterminate period. By way of comparison, I understand that the Defence Secretary established a Covid Support Force ("**CSF**") on 18 March 2020 to assist public services with the pandemic response through MACA requests. The CSF was comprised of 20,000 personnel held at graduated readiness, with up to 4,000 committed on most days. As such, were the MOD to provide the supply chain service, that would tie up a substantial proportion of MOD capacity and prevent the MOD from responding to other MACA requests which were received from time to time.

d. **Fourthly**, I was concerned to avoid the MOD becoming tied-in on a task to the detriment of its other primary function of maintaining a state of military readiness. I had received a direction from my commanding officer, Lieutenant General Michael Elviss (then Major General), who was the General Officer Commanding 3rd (UK) Division, that I should not remain at Skipton House longer than necessary, as it was imperative for the MOD to return to its usual warfighting function as soon as reasonably possible. This direction was made through an email[13] and an oral discussion which took place around the same time. The early pandemic was a time of substantial geopolitical uncertainty. In particular, the situation regarding Russia was becoming more concerning to the MOD. Committing myself and a substantial number of MOD personnel for a substantial time period would potentially prevent the MOD from fulfilling its core warfighting function.

36. Given the above, it was my strong view at the time that other options, beyond simply the MOD 'doing it' needed to be explored urgently. I reached out to contacts with logistics expertise in order to gather information about potential solutions. I contacted Neil Ashworth, who was a member of the Engineer and Logistic Staff Corps ("**ELSC**"), which is a voluntary corps of individuals with engineering and logistics backgrounds, largely in the civilian sector. Mr Ashworth had significant experience in the commercial logistics field as he had previously acted as the Chief Commercial Officer of the logistics company Yodel. The ELSC provides mentors to Army personnel in order to allow the Army to take advantage of that experience. Mr Ashworth had been assigned as my mentor during mid-2019. I had spoken to him on two occasions before this, during which we had discussions about modern-day logistics. These discussions related entirely to logistics. I am not aware of Mr Ashworth having any political affiliation or links to any political party.

37. I had a phone call with Mr Ashworth on (I believe) Sunday 22 March 2020. His view was that a commercial third party could be able to provide the solution that I was looking for. Particularly, I recall that he noted that many logistics companies would have spare capacity; routine operations such as deliveries to non-essential shops would have ceased. He mentioned Clipper Logistics ("**Clipper**") to me, as Clipper had a substantial distribution network available to it and would have ceased a substantial proportion of its routine operations as, I understand, Clipper's usual business included the distribution of clothing to high street fashion brands including John Lewis. Mr

[13] **[PP/08 - INQ000534264]**

Ashworth offered to reach out to Clipper, as I believe he had contacts in Clipper's senior leadership. I can confirm that prior to this point, I had never heard of Clipper; nor had I had any contact with senior personnel at Clipper.

38. I believe that at this point I would have informed Ms Lawson that I had reached out to Mr Ashworth and that Mr Ashworth had offered to reach out to Clipper. As Ms Lawson was SRO on the PPE Team, I kept her informed of my actions at all times so far as possible. I have no doubt given the significance of this work, that I would have been keeping her informed of my progress. However, I do not specifically recall when I informed her of the above matters.

39. On Monday 23 March 2020, the day that the national 'lockdown' was announced, a meeting was held between myself, Jim Spittle and Mr Sahota of SCCL, Frank Burns of Unipart, Ms Lawson of NHSE, and Tony Mannix, who was the CEO of Clipper. I did not set up this meeting. I believe that it is likely that what happened was that Mr Ashworth had reached out to Clipper as he had said he would, and then put Clipper in contact with Mr Spittle of SCCL or, more likely, Mr Burns of Unipart, with whom Mr Ashworth also had a professional relationship. My impression during this meeting was that discussions had already taken place between Clipper, SCCL and Unipart. I am not aware of the content of those discussions. However, during the meeting on 23 March 2020 the representatives from Clipper, SCCL and Unipart presented to Ms Lawson a plan for working together to provide the necessary distribution services. I presume that the content of that presentation arose from those previous discussions.

40. My recollection is that there were some outstanding issues to be ironed out, so Clipper, SCCL and Unipart agreed to have a further meeting to resolve those matters. I recall that I asked them to report promptly. In preparing this statement I have reviewed an email from Mr Sahota dated 24 March 2020, in which he states that I "*instructed the parties to meet again and report back at 11am today on a solution for how this dedicated channel could be achieved*". I do not believe that this accurately reflects matters. I do not believe it is at all likely that I would have directed the parties to meet again; it would not have been my role to give such a direction. My recollection is that it was something they agreed of their own volition.

41. I do recall that I impressed the urgency of the situation upon them: although given the context, I doubt they were unaware, and I expect that I would have asked that they report back on their discussions promptly. I do not recall explicitly 'instructing' them to report back by a particular time; however, it is likely that I would have used language which reflected the urgency, and language which was clear and precise about

expectations, in line with my military background, in which clear action points are imperative (and thus tend towards the use of forceful language) and the urgency of the situation. In any event, even if it is the case that the language of one of 'instruction' to report back, I was not the decision-maker on whether to engage Clipper. I was concerned solely to ensure that a decision was made rapidly. My impression when I arrived at NHSE was that decisions on logistics were not being made quickly enough, and that some of the PPE Team had not yet adopted the 'wartime mindset' necessary to respond to the unprecedented situation facing the country. Accordingly, I encouraged the parties to speed up their decision-making process, although the decision remained theirs to make.

42. In Mr Sahota's email of 24 March 2020, he informed me that the parties had agreed that the most effective way to engage Clipper's services would be through a direct contract between Unipart and Clipper. Unipart already had a contract for the provision of distribution services with SCCL, and so rather than creating a new and bespoke contract between SCCL and Clipper it was agreed between those parties that it would be more effective for Unipart to sub-contract with Clipper, with the arrangement ultimately managed by NHSE directly.[14] I understand that daily management of the parallel supply chain would be undertaken by a Joint Control Tower staffed by SCCL and Clipper.[15] I do not believe that it had been decided by NHSE at this point to bring Clipper on board. Indeed, in that email Mr Sahota referred to discussions he had had with DHL, the logistics company, and to the possibility of engaging DHL to perform the role which was ultimately performed by Clipper. My recollection is that this email is the first time that DHL was mentioned, as Mr Sahota had not mentioned those discussions with DHL to me before that point.

43. I am unaware of subsequent discussions and negotiations between SCCL, Unipart, NHSE and/or Clipper, as my role was purely operational rather than commercial. However, I was later informed that Clipper had been selected to provide the distribution services. I was not part of that decision and nor am I privy to the reasons why Clipper was selected over DHL. I would presume that that decision was made by NHSE, although I am not aware of the identity of the decision-maker. I do not believe that any MOD personnel were involved in that decision. I infer that the decision was made between 24 and 26 March 2020, before the first goods arrived at Clipper's facilities on 27 March.

14 [PP/09 - INQ000534273]
15 [PP/10 - INQ000534265]

44. I have recently become aware from reading the Module 5 corporate witness statement of the Department for Health and Social Care, which I have been given permission to read by the Inquiry, that the Government Supply Chain Cell had been established during February 2020 and had, since early March 2020, been engaged in discussions on establishing a parallel supply chain. I was not aware of or privy to any such discussions.

45. I understand that Clipper began work immediately and that SCCL brought in consultants in order to integrate Clipper into the SCCL systems. I understand that a small number of MOD personnel were involved in the process of onboarding Clipper. However, as was the case regarding the MOD's involvement in the PPE Team more generally, such personnel were brought in to improve the effectiveness and efficiency of decision-making processes rather than make any decisions themselves.[16]

46. It is my understanding that the first goods arrived at Clipper's facilities on 26 March and the first shipment was on 29 March 2020.

47. I also ordered that two Immediate Replenishment Groups ("**IRGs**") should be established in the North and South of England to ensure that if any Trust became critically short of PPE, they had access to a 24/7 mechanism by which they could replenish stocks. The IRGs were tasked by the National Supply Disruption Response Hotline (the "**NSDR Hotline**"). As I understand it, the NSDR Hotline had been established as part of contingency planning for Brexit, and allowed healthcare organisations with an urgent need for PPE to call and secure emergency supplies. It was reactivated before my arrival at NHSE to support the distribution of PPE during the pandemic, acting as a 24-hour service available across the four nations.

48. In my view, the outbound supply chain established by Clipper was successful. It exhibited the key features of a successful outbound logistics process, namely: the supply chain was precise in that only the necessary stock was distributed to end-users; it allowed PPE to be distributed quickly, which was key as end-users held low levels of stock; and it was transparent in that front line staff knew what would arrive and when, and therefore could have confidence that they would be able to operate safely. I address the decision-making and information gathering processes used to secure these attributes below.

[16] See, for example, **[PP/11 - INQ000534280]**, which is a document produced by Major Eb Mukhtar providing an overview of the Clipper arrangement and detailing action points which Unipart was to complete in order to activate the Clipper supply chain. No action points were for the MOD to complete, as the MOD's role was confined solely to improving the operational processes of other parties.

49. In addition to my work in relation to the distribution element of the supply chain, I also worked to establish an inbound logistics process to deal with the increased quantities of PPE coming into the storage and distribution network provided by Clipper. Clipper's role was to distribute PPE which was already in the supply chain, and so I was involved in working to ensure that PPE was brought into the network from suppliers and manufacturers (many of whom were based abroad, including in China) as effectively as possible. At the outset, there were difficulties tracking the location of PPE between the time of purchase and time of arrival in the network. Without sight of the expected time of arrival of PPE supplies, NHSE could not make effective distribution decisions. Accordingly, my team worked to establish systems by which stock could be tracked, including through contacting suppliers and Buy Team leads. Ultimately, NHSE adopted an automated information system named 'One World' to track PPE orders.

50. I similarly consider that the inbound logistics process we implemented was successful. It secured the key features of a successful inbound process as follows: it ensured PPE flow into the network without blockages; it assured PPE quality and standards; and it provided transparency so we could know when PPE would arrive with confidence. The last point was particularly important, as such information was needed to effectively plan onward distribution. As such, the systems established by my team to track stock proved extremely valuable.

iii. Involvement in decision-making processes

51. During my deployment I worked with the NHSE PPE team to bring more structure to the daily battle rhythm of meetings. Battle rhythm is a military term that is used to describe the cadence of meetings that brings the right people together, with the right information, at the right time to share information, or make decisions. The SRO, Ms Lawson, was at the beginning of the pandemic hampered by ineffective processes. By this, I mean that she was the single point of contact for many decisions, with no one setting a programme of work or decision-making. There was a real absence of structures designed to support Ms Lawson. In my view, due to those ineffective processes, she was required to spend too much time trying to make sense of the information flowing into Skipton House, rather than making decisions consequent on that information. I say the above not as a criticism of Ms Lawson or of NHSE; NHSE simply had not been set up or structured to manage a national crisis of the scale of the pandemic. Indeed, in my view Ms Lawson performed impressively throughout the pandemic.

52. I began to facilitate the meetings so that relevant information for decision-making was presented in a more efficient manner. This involved, *inter alia*, tightening up the daily agenda so it had a greater focus on the events of the preceding 24 hours (such as evidencing the demand signal and supply capacity); bringing greater focus on major activities in the short-term future; and integrating major stakeholders into the daily meetings in order to brief the SROs on the actions of various parties. However, whilst my team was seconded into NHSE, all decisions were made by NHS personnel. As far as I am aware, Military personnel (and also consultants and industry partners present from time to time) acted in a purely supporting capacity.

53. The touchstones of the daily battle rhythm were the daily 0830hrs and 1800hrs meetings.

54. Daily activity was coordinated during the 0830hrs daily calls, in which key stakeholders were updated on overnight events, operational insights and key activities which were upcoming. It included a summary of issues which needed to be resolved and it set the agenda and priorities for the coming day. Any calls which had been received overnight by the NSDR Hotline would be reviewed at the 0830hrs meeting.

55. This meeting was initially chaired by Ms Lawson, who was subsequently joined by Lord Deighton and Jonathon Marron, all of whom co-chaired the meeting. My understanding is that these meetings had three 'chairs' to reflect the different and in some respects competing demands on PPE. I would work with Efficio Consulting, who I understand were on contract to deliver project management office services, including closing actions, distributing agendas, and booking facilities in which meetings would happen. I understand that Efficio had been embedded into the PPE Team before my arrival, and it was only some weeks into my deployment to NHSE that I became aware that they were an external party and not part of NHSE.

56. The 1800hrs meetings, which were co-chaired by Ms Lawson and Mr Marron and facilitated by myself, were largely concerned with allocation and distribution. They were also attended by NHS regions in order to improve transparency.

57. At the meetings, an allocation and distribution decision Brief, provided by the MOD/McKinsey Supply & Demand Data Cell, would be given to NHSE decision-makers. The Brief used a decision tool built by the MOD and McKinsey and approved by NHSE.[17] A Tiger Team[18] of four MOD personnel was used to chase inbound logistics

[17] [PP/13 - INQ000561729], [PP/14 - INQ000561730]
[18] Being a small team engaged in a bounded and time-limited task.

requests and other critical gaps, in order to ensure that the Brief given was as comprehensive as possible. Using the Brief provided, NHSE decision-makers would confirm the distribution plan for the forthcoming three days based on data on usage rates, stock levels, likely surges and other relevant factors.

58. This was an evolutionary process, as there were difficulties in understanding and modelling future demand for healthcare equipment. Prior to the pandemic, regular procurement of PPE was decentralised across health and social care settings. NHS Trusts in England could procure their own PPE independently or via the NHS supply chain. Other health and social care organisations (including primary care organisations) were responsible for procuring their own PPE through wholesalers or directly from suppliers. These factors, in addition to the change in the PPE demand profile caused by the pandemic, meant that NHSE did not and could not have an accurate understanding of demand at the outset of the pandemic.[19]

59. However, as the PPE Team began to understand the country's demand profile better, the allocation system similarly improved. To further improve the allocation system, the PPE Team worked with Palantir, using its foundry system to improve analytics and data, and McKinsey, who in tandem with MOD personnel built the model used to inform NHSE decision-making, as noted above.[20] Palantir's role was to ensure that the data to be presented was as current as possible, and to ensure that the data was of sufficient integrity that it could be trusted. Through doing so, robust recommendations for distribution were created that would meet known demand, anticipate future demand, and balance distribution to ensure that scarce stock could be allocated where it was needed most.

60. I also worked to integrate the Buy Team into the decision-making process. As may be trite to say, one cannot make effective decisions on the distribution of PPE if one does not know how much PPE is available on the supply side of the equation. And, vice versa, one cannot make effective decisions on what PPE should be purchased if one does not know what is needed. Accordingly, it was necessary to integrate the Buy Team into the daily battle rhythm so that decision-makers had visibility across the supply chain. However, that was the extent of my involvement in the procurement-related side of matters. I did not make any decisions related to procurement, as all decisions were made by NHSE personnel including Ms Lawson and Ms Marrow, and I did not have

[19] [PP/12 - INQ000527998]
[20] [PP/13 - INQ000561729] [PP/14 - INQ000561730]

any involvement in the internal processes of the Buy Team, although I understand that they were as described in the Module 5 Statements.

61. Once Ms Lawson and Mr Marrow had made a decision on allocation and distribution of PPE, the distribution operation would begin the distribution process in order to ensure that all dependent users received stock sufficiently promptly. Four MOD personnel were based with Clipper at their National Distribution Centre located in Daventry to assist with the operational tempo required to meet the high level of demand, and to assist informational flow between NHSE and Clipper. I understand that they should not have been involved in any formal contractual performance discussions between Clipper, SCCL and NHSE.

62. The Inquiry has asked me to provide additional information on the Daventry facility and MOD personnel based there. Such matters are addressed more fully in my second witness statement. However, for present purposes: those personnel were under the command of SJC Headquarters. However, due to Skipton House's operational dependence on the Daventry personnel, my team would communicate with them on a daily basis to ensure that we had a good understanding of the situation on the ground. In doing so, I acted in a collaborative manner with the Daventry personnel rather than in a supervisory role; they were not under my command, but I worked closely with them. Decisions on the PPE to be distributed were made during the daily 1800hrs meetings described above. Once the decision was made of what stock was to be sent to which end-user, stock would be picked, packed and distributed immediately to be delivered within 48 hours.

63. Issues were anticipated and resolved through the mechanism of the daily 0830hrs and 1800hrs meetings. Resolution would be based on understanding what the problem was, identifying a series of choices and then making sure that the right decision-maker at the right level was provided with the necessary information to make a decision. Decisions would be taken at the daily meetings so far as possible in order to ensure rapid and effective decision-making.

64. In my view, the two daily operational meetings provided an agile platform. We were able to effectively learn and evolve our processes in response to issues that arose. This iterative process worked extremely well.

65. In addition to the daily meetings, over time additional meetings were established to address short, medium and long-term planning using NHS modelling as required. In my final few weeks, Sales and Operations Planning meetings took place in which

NHSE assessed future procurement planning for different PPE categories against stock requirement levels.

66. Finally, in addition to the above there were many meetings for the Department for Health and Social Care ("**DHSC**"), NHS executive, and programme boards. I did not design or attend such meetings.

67. As substantial parts of my day were spent in the above meetings, I predominantly communicated with others orally rather than through electronic communication methods such as email. In view of the tight timescales we operated under, in my view oral communication was the more effective route in terms of rapidity. There were also challenges of working across the MOD / NHS digital boundary and emails would often get quarantined. It was too risky to lose emails in this manner, as all actions were urgent and important. Where oral communication was not possible, I communicated via WhatsApp. The WhatsApp groups of which I was a member are as follows:

    a. 101 Log Bde in Skipton House. I joined this group on 20 March. As the title implies, the members of the group were all military personnel. The group was mostly used for food and administrative matters. It was occasionally used to discuss work matters, although I recall that this was mostly the coordination of meeting times rather than substantive matters.

    b. A PIDU[21] WhatsApp group. I joined this group on 2 June. The group contained Rear Admiral James Higham, the head of PIDU, Ali Gutzu, who was Rear Admiral Higham's assistant, Tom Dee, Efficio Consulting, and Stef Buttery, who I recall to be a Navy SO3 problem solver.

    c. An NHS Gold WhatsApp group. This group focused on addressing wider operational planning issues in the NHS. It did not address either PPE or procurement.

    d. A Regional Commander WhatsApp group. This group contained regional brigade commanders and focused on the wider pandemic response. It contained very limited discussion of PPE related-matters, and, as I recall, no discussion of procurement-related matters.

iv. The Programme Integration and Development Unit

[21] The 'Programme Integration and Development Unit'. I discuss my involvement with PIDU below.

68. The Programme Integration and Development Unit ("**PIDU**") was established in April 2020 to improve the coordination of the PPE Team's leadership in order to ensure coherence and alignment across the supply chain and decision-making process. The PIDU was headed by Rear Admiral James Higham, who would meet with Ms Lawson, Mr Marron and Lord Deighton to discuss strategic and operational requirements. I would attend some of these meetings with PIDU, during which PIDU would consult me on the various operational changes that they implemented, although the decisions were ultimately theirs to make.

69. The PIDU was created to ensure that the PPE Team's operating model developed quickly and effectively to provide appropriate governance to the decision making processes, and tighten business planning to further develop the maturity of the programme. As one would expect, the PPE Team ballooned in size during the early period of the pandemic, which brought with it the inevitable teething issues caused by increasing scale and complexity. The PIDU was established to address these issues.

v. My working relationship with Jonathon Marron and Emily Lawson

70. The Inquiry has asked me to specifically address how I worked with Mr Marron and Ms Lawson to resolve issues related to the procurement and distribution of PPE. The majority of my working relationship with those individuals was through the daily 0830hrs and 1800hrs meetings detailed above. We would spend substantial parts of the day together in deep dive meetings, or in other forums.[22]

71. If any particular issues would arise, such issues would be resolved either by direction to leaders to cover the issue in one of our meetings, or it would be subject to a stand-alone deep dive meeting. If the problem was large enough, a sprint team/Tiger Team would be formed to address it. If resolving a problem required external DHSC support, Jonathan Marron would act as a lead. If resolving a problem required government support, then we would discuss the best approach, and if a direct line to Number 10 was needed, then Lord Deighton would lead. The processes used were dynamic but were informed by the governance and improving maturity of the processes established by the PIDU.

[22] [PP/15 - INQ000561731] [PP/16 - INQ000561732]

vi. Key issues encountered in the procurement and distribution of PPE

72. The Inquiry has asked me to address the key issues I encountered in the procurement and distribution of PPE. These issues are as follows:

a. **First**, the lack of understanding of the demand profile in the early days of the pandemic. As set out above, NHSE did not have such data at the outset because substantial amounts of PPE were procured by end users prior to the pandemic. As set out above, this issue was resolved by working with consultants and industry partners to understand the demand profile through data.

b. **Secondly**, the lack of understanding of the supply base, which was compounded by substantial global competition for PPE, the global lock down, and China shifting its manufacturing base. However, as procurement was not my responsibility, I cannot comment on the steps that were taken to meet this challenge.

c. **Thirdly**, the speed at which enabling activity was conducted by organisations such as the Medicines and Healthcare Regulatory Agency, Public Health England and other regulatory bodies responded to requests to certify equipment was not quick enough to meet operational timelines. In my view, this problem arose from an initial failure to appreciate the urgency of the situation, which was soon remedied as those bodies adapted their mindsets to the 'war-time' approach bodies needed to adopt during the pandemic.

d. **Fourthly**, during the early days of the pandemic the process for obtaining financial and commercial approvals was not clear and therefore not agile enough to close deals quickly. This issue was resolved by the establishment of the Deal Approval Committee (although I was not involved in that Committee or the establishment thereof).

e. **Fifthly**, visibility of stock and the quality of said stock was limited as the logistics operation was newly established. These issues were resolved over time as our processes matured, although as discussed above substantial steps were taken in relation to those matters.

vii. The devolved administrations

73. The Inquiry has asked me to specifically address my work with the devolved administrations on the distribution of PPE. I did not work closely with the devolved administrations. However, I am aware that Ms Lawson would engage with her opposite number in each devolved administration. In addition, the Chief Medical Officers were present on DHSC Programme Boards, and the Buy Team engaged with their devolved counterparts to ensure opportunities were known. Mutual aid was often discussed at the daily 1800hrs meeting.

74. I am not aware of any particular issues in relation to the devolved administrations.

D. Issues relating to the gathering of data on PPE procurement and distribution

75. The Inquiry has asked me to specifically address issues I encountered in relation to the gathering of data on PPE procurement and distribution. As I have discussed above, NHSE were attempting to balance scarce supply against record demand, with limited data on demand available as PPE had not been centrally procured and distributed prior to the pandemic.

76. In order to manage data effectively, it was necessary to define what was meant by 'PPE'. I understand that DHSC agreed on nine categories. Once those categories had been agreed, NHSE requested users to report stock held and, using a combination of actual usage rates since the start of the pandemic and user estimates on requirements, we predicted where items were needed most. This was a manual process but was later automated through working with Palantir and NHS Digital. Where there were obvious and urgent supply shortfalls, that was fed into the Buy Team to prioritise those items.

77. The data which was collated was used to consolidate the national demand and supply plan and, using an algorithm, a series of recommendations for distribution were created. It was not the case that recommendations were necessarily followed, as, in the early days, the recommendations were produced by a work-in-progress algorithm which had not yet captured the demand-side of the equation perfectly. Given the paucity of stock, there was often a risk-based approach whereby the SROs would make the decision when stock was needed rather than try and predict where stock was required too far in advance. This was complicated by a lower guarantee of quality as a result of new markets being used for PPE, and immature data for inbound logistics. Due to uncertainty as to the quality of products from new suppliers, significant steps were taken to ensure that quality was not compromised, including quarantining stock from new suppliers in order to undertake quality assurance testing before making the

stock available for distribution. These complexities slowed down the operation and created blockages. However, as I have discussed, we were engaged in a constant process of refinement and improvement of our processes, working with partners including Palantir, McKinsey, and NHS Digital.

E. Lessons learned and reflections on procurement and distribution processes

78. In my view, the pandemic exposed the vulnerabilities of supply chains, which had been designed for predictable worlds and for efficiency. The pre-pandemic approach of government procurement was to focus on price in an effort to protect taxpayer money. However, the pandemic necessitated a greater focus on obtaining value rather than just price. By value, I mean that one needs to look holistically at the benefit to be obtained from the contract; PPE which is available immediately has far greater value than PPE available in the future, even if it may be at a greater price. I believe that NHSE and the civil service generally responded impressively to this shift in approach, particularly in relation to the Buy Team, Make Team, and the rapid adoption of technology. NHSE also took advantage of commercial expertise to ensure longer term contracts, utilise novel payment approaches to speed up transactions, and improve supply chain understanding to get to the manufacturer rather than agent, and understanding the end to end dynamic to unblock flow constraints. In my view, that 'value-focused' mindset should be embedded in government to a greater extent.

79. However, the pandemic has taught us that supply chains need to be designed for a purpose, and that if there is a reasonable risk of another pandemic, then the NHS will require sufficient resilience in terms of responsiveness, capacity, and operational excellence within its supply chain. The pressure now is to become more precise and to run more efficiently so that the UK can afford to build in the resilience which may be required. This may mean investing in sovereign manufacturing capability.

80. In terms of logistics, in my view the logistics information systems were not well integrated or modernised. Unfortunately, whilst the NHS had a transformation programme planned to move from Green Screen to Oracle during 2020, this programme was paused due to the pandemic. Whilst there were flaws with information systems, the physical infrastructure was in my view well-designed, used effectively, and provided the buffer stock required (albeit imperfectly).

81. More generally, the pandemic has forced a rethink on the pace and scale of crisis response that any government may have to provide. The UK has a long history of mistaking lean with agile, meaning that we have cut capacity in the honest belief that we can still react to the unforeseen across all government departments.

82. I believe that The UK Government must perfect the balance between outsourcing and internal performance. The matters suitable for outsourcing must be defined and managed, and the matters performed in-house must be critical and provide sovereign capability where it is needed most. The UK must deliver an operational model which works in each department and is integrated across the whole of government. Data must form the basis of this model, but only when the time is right. We should not seek to digitise before the architecture is mature enough to deliver the product which is required. However, in order to speed that process, the UK needs to improve digital skills amongst its leaders.

83. In terms of specific lessons, I would highlight:

    a. When considering supply chain design, it is necessary to appreciate the importance of: understanding various roles and responsibilities across the enterprise; end-to-end visibility; stress testing the supply chain against worst case scenarios; and (when appropriate) digitising the enterprise to speed up decision-making.

    b. When undertaking procurement planning, early market engagement and market intelligence are necessary to ensure that trends and technology can be explored early. This includes a proactive approach to risk management across the wider supply chain ecosystem, monitoring sectors and 'similar to' industries in order to pre-empt problems.

    c. Logistics excellence is required, with network design and optimisation activity geared to continuously adjust capacity to meet spikes in demand. The importance of understanding the demand signal and the importance of prioritisation from procurement through to distribution is vital.

    d. Financial and commercial agility were enabled and can be enabled by government. For example, the New Supplier Team led by DE&S, in which commercial staff from across 17 Government Departments, came together quickly to assist the procurement of PPE. Financial approvals were expedited by having common processes allowing resource to be moved quickly and effectively.

e. Product complexity must be factored into all planning when any supply chain is scaled significantly. Quantity inevitably adds complexity to what is already a complex and highly regulated area. Product complexity also means that scaling up domestic manufacturing will require significant focus and investment.

f. Organisational design and maturity is an important factor in crisis response. NHSE and NHS Improvement were combined in 2019, which meant that many processes and governance forums were still being developed.

g. Data and technology are vital to speed up understanding and decision-making. However, to be dependable, data must be managed and curated with near obsessive levels of attention. Further, architecture must be designed to deliver business needs whilst looking to minimise integration by design, but speeding up integration where required. The UK also needs the skills to continuously digitise processes so that problems solved quickly. This will not happen without the right people with the right skillset, paving the way to the future.

STATEMENT OF TRUTH

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

Signed: Personal Data

Dated: 21 January 2025

IN THE MATTER OF THE COVID INQUIRY

EXHIBITS TO THE WITNESS STATEMENT OF

MAJOR GENERAL PHILLIP PROSSER

Exhibit	Document	Author	Date
PP/1	JDP 4-00 Logistics for Joint Operations Fourth Edition	MOD	July 2015
PP/2	Defence Academy of the United Kingdom website	MOD	
PP/3	20200319-NHS-MACA Request	MOD	19 Mar 2020
PP/4	Joint Doctrine Publication 02, UK Operations: the Defence Contribution to Resilience, Fourth Edition	MOD	28 Nov 2022
PP/5	FW:20200319-NHS-MACA Request.	MOD	19 Mar 2020
PP/6	20200319-RESCRIPT MACA NHS(L)-JRLO-20_032-Extension-OS	MOD	19 Mar 2020
PP/7	20200320-UK_Resilience_Doctrine	MOD	20 Mar 2020
PP/8	20200511-RESCRIPT_MACA_101_Log_Bde_Sp to PPE_Distr-OS-20-035_AMDT 002.doc	MOD	11 May 2020
PP/9	Model for dedicated PPE Channel	MOD	24 Mar 2020
PP/10	RE: Update requested	MOD	27 Mar 2020
PP/11	PPE Overview and Key Action	MOD	
PP/12	202000420-MOD Assistance to PPE slides	MOD	20 Apr 2020

PP/13	20200506 101_Log_X_30_Day_RESCRIPT_OP_Review	MOD	6 May 2020
PP/14	20200420-MOD Assistance to PPE slides	MOD	20 Apr 2020
PP/15	Slides for 1300 – please circulate	McKinsey & Company	28 April 2020