IN THE COVID PUBLIC INQUIRY

BEFORE THE RT. HON BARONESS HALLET

DEPARTMENT OF HEALTH AND SOCIAL CARE

MODULE 5 CLOSING SUBMISSION

INTRODUCTION

1. The Department of Health and Social Care ("the Department") reiterates its deepest sympathies to all those who lost relatives and friends during the pandemic and to those who continue to deal with the long-term consequences of the pandemic. The disruption and effects of COVID-19 on our society were profound and were particularly impactful within the health and social care system.

2. The Department would like to take this opportunity to repeat our thanks to those who responded to the pandemic, particularly, those working within the NHS and social care sector, to those who responded to the Government's 'Call to Arms' and to the Department's permanent and temporary staff who worked tirelessly to ensure that PPE, oxygen and ventilators were made available to those who needed them most. As the Inquiry has learned, the pressure to provide equipment and PPE to the front line was profound, the fear of running out of stock was all too real and weighed heavily on every single member of the team.

3. As set out in the Department's opening statement,[1] alongside the rest of Government, was reacting to a pandemic of unprecedented scale and dealing with a novel virus of which, in the early months of 2020, there was little scientific understanding. Whilst there was a plan in place to respond to a reasonable worst-case scenario (RWCS) influenza pandemic, the emergence of COVID-19 resulted in unprecedented increases in global demand for medical equipment and devices, alongside significant disruption to global supply chains.

4. The majority of ventilators and PPE were, and continue to be, manufactured in far east countries such as China and Malaysia. There was only a limited UK manufacturing base, that is still true today.

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[1] INQ000574848

5. In early 2020, the Chinese government introduced restrictions; only allowing certain exporters on a 'white-list' to export goods which resulted in acute challenges to established business-as-usual (BAU) procurement channels in the UK. The situation was exacerbated by other international demand, huge competition within the global marketplace and some countries 'gazumping' i.e. offering above market prices to secure products. Once the pandemic escalated in the UK, BAU procurement channels were overwhelmed by the global situation, the massive spike in PPE and ventilator use, and the increased demand from NHS Trusts to bolster localised stockpiles. Whilst the number of reported cases in the UK was minimal in the early weeks and months of 2020, the marketplace had already become distorted. The Department was acutely aware of the impact that extreme supply constraints and uncertainty had on frontline health and social care staff.

6. Prior to the pandemic, BAU procurement was the responsibility of individual providers. NHS procurement was either carried out directly with private wholesalers or via Supply Chain Coordination Ltd (SCCL). For non-NHS providers (including adult social care (ASC) and GPs), private wholesalers were the main source of PPE.

Ventilators

7. The Department worked together with NHS England (NHSE) on procurement of ventilators. The Department mobilised rapidly in February/March 2020 to increase confidence in modelling estimations and to respond to the initial surge in demand. Existing SCCL framework-agreed suppliers were contacted and awarded contracts by SCCL; however, this procurement route was unable to secure the volume of ventilators required. Therefore, the Department worked with the Foreign and Commonwealth Office (FCO) and Department for International Trade (DIT), who, through their network of embassies, supported the identification of new sources of international supply.

8. Following the Prime Minister's 'Call to Arms' on 16 March 2020, the Department for Business, Energy and Industrial Strategy (BEIS which later became DBT) provided a triage service on behalf of the Department, which responded to the high-volume of offers received from new sources of UK supply. In parallel, the Cabinet Office (CO) launched the Ventilator Challenge with the objective of procuring additional ventilators, from non-established suppliers that could shift manufacturing capacity.

9. The Department's newly established, on 3 March 2020, Oxygen, Ventilation, Medical Devices and Clinical Consumables (O2VMD&CC) programme faced and overcame a

number of challenges in the early stages of its response to ventilator procurement. These challenges included, understanding and procuring against the changing clinical requirement of COVID-19, as well as data gathering, logistics, allocation and distribution processes.

Personal Protective Equipment (PPE)

10. The Department convened and mobilised the 'Supply Chain Cell' (the Cell) at the end of January 2020 at the request of the NHSE Incident Response Team. The purpose of the Cell was to manage challenges in product supply and to provide strategic oversight, alongside other key stakeholders, of the continual supply of all clinical consumables through BAU procurement channels. From 5 February, the Cell made the EU stockpile available for release. On 7 February 2020, they instructed SCCL to procure additional PPE and from 3 March 2020, they agreed for products to be released from the Pandemic Influenza Preparedness Programme (PIPP) stockpile.

11. To ensure frontline health and social care facilities (including GPs, ASC providers, and pharmacies, etc.) received these initial supplies of PPE, the Department organised emergency drops to healthcare providers across England.

12. The Department's National Supply Distribution Response (NSDR) Team (originally created to support with a 'no-deal' EU exit) was reactivated on 16 March 2020 to support access to emergency supplies for all health and social care providers expecting to run out of PPE within 72-hours.

13. Supply issues persisted and by mid-March 2020, it was made clear that SCCL's existing infrastructure for procurement and distribution could not deliver the volume of PPE required to meet the increased demand. In a collaborative effort with CO and NHSE, the Department established an end-to-end supply chain to model demand and to procure, import and distribute PPE to supplement SCCL contracts awarded via their existing framework-agreed suppliers. This became known as the 'Parallel Supply Chain' and was managed by the newly established 'PPE Cell', separate to the Supply Chain Cell described above.

14. Similar to the O2VMD&CC programme, the PPE Cell worked closely with FCO, and the British Embassy Beijing. The Embassy supported the identification of new China-based sources of PPE supply. Additionally, BEIS, on behalf of the Department, established and

scaled-up UK-based manufacturing, and a CO team triaged and considered offers from other sources, including the Department's Call to Arms.

15. In setting up the Parallel Supply Chain, the PPE Cell was challenged by the devolved nature of procurement and logistics, with no centralised information or supply resilience. This meant that the PPE Cell had to establish clear sight of stock levels and demand signals across the health and social care system and distribution routes that could handle what the Chief of the Defence Staff, General Sir Nicholas Carter, described as "*the single greatest logistic challenge that I've come across*" in more than 40 years of service.[2] The Department addressed these challenges by establishing and formalising governance structures and an end-to-end supply chain from scratch, at pace, whilst adhering to and adjusting to the difficult circumstances of responding to a pandemic, such as lockdowns, shielding and the necessity to work from home.

PRE-PANDEMIC PREPARATIONS

The PIPP Stockpile

16. The types and volumes of PPE held in the PIPP stockpile were based on clinical recommendations from the New and Emerging Respiratory Threats Advisory Group (NERVTAG), overseen by Public Health England (PHE) and held by SCCL subcontractor, Movianto. The intended purpose was to supplement BAU procurement in the first wave of an influenza pandemic, estimated to last for 15-weeks (based on the RWCS for pandemic influenza). Although the COVID-19 pandemic was caused by SARS-Cov-2 coronavirus, rather than influenza, the PPE held in the PIPP stockpile was just as essential for protecting patients from COVID –19 as it would have been for influenza. The EU Exit stockpile was rapidly consumed at this time to help ameliorate short-term variations in supply.

17. The underpinning analysis that formed the PIPP stockpile composition – both product type and volume - was based on various assumptions, including the number of each item needed for each patient interaction for symptomatic influenza pandemic patients only. The analysis did not account for PPE needed in treating asymptomatic COVID-19 patients, which was subsequently required following improved understanding on the transmissibility of COVID-19 or protecting patients and staff for all patient interactions regardless of

[2] INQ000279949

symptoms or diagnosis. Further the need to support BAU supply chains (which were also subsequently required due to the extraordinary pressure sustained by the global PPE market) had not been anticipated. For these reasons the levels of demand and usage experienced during the pandemic were much higher than had been expected under pre-pandemic planning.

Gowns

18. As set out in paragraphs 204 to 207 of Jonathan Marron's First Witness Statement dated 16 December 2024,[3] the PIPP stockpile did not remain static; items were added or updated as evidence evolved. NERVTAG had recommended gowns be added to the pandemic stockpile for use during splash-prone or aerosol generating procedures (AGPs). This recommendation was agreed and ratified by the Clinical Countermeasures Management Board (CCMB) on 9 October 2019 and SCCL developed market analysis for PHE, which was to be used to make recommendations to the Department on procuring gowns. At this time, the Department was operating under competitive tendering exercise BAU procurement regulations, and a procurement exercise was underway to procure 19,340,700 gowns. CCMB minutes from previous procurement rounds show that requiring financial approval from all four nations in the Union would typically take 9-12 months. Sir Chris Wormald has previously stated[4] normal government procurement processes will take many months.

19. By early February, SCCL had begun buying gowns and Department officials encouraged them in their efforts to do so; however, their framework suppliers reported challenges in meeting the increased demand and procurement exercise was not completed. It was not possible to procure at speed, for example by direct award, until PPN 01/20 was introduced on 18 March 2020.

Just-in-Time (JIT) Contracts

20. The first case of COVID-19 in England was confirmed on the 31 January 2020. Prior to that, on 27 January 2020, SCCL began engaging with suppliers on existing PIPP JIT contracts. The first JIT order for 6.8 million FFP3 respirator masks was placed on the same day and subsequent orders for products on additional JIT contracts followed throughout early February 2020, but all were impacted by supplier delivery failures. JIT contracts had

[3] INQ000528391
[4] Page 13 - PHT000000124

been designed to augment, not replace, the contingency stockpile physically held in the UK with the combined amount of PPE totaling the estimated demand modelling for each type of PPE.

21. JIT contracts had been awarded to suppliers with capacity beyond the UK's BAU requirements. Supplier capacity was checked every six months to ensure they could meet operational obligations during a pandemic.[5] These contracts had been negotiated to secure delivery at pre-determined costs before the pandemic.

22. The Department believed the rationale to hold JIT contracts as part of a portfolio of resilience was sound; doing so reduced storage costs and reduced waste due to expiry of items. However, the pandemic exposed limitations in the JIT approach. Most JIT contracts depended on manufacturing bases abroad and were impacted by global supply chain disruptions. This included lockdowns, export controls and border closures which disrupted manufacturing and logistics, making it difficult for suppliers to fulfil JIT contracts. For example, a French supplier who was party to a JIT contract was unable to deliver FFP3 respirator masks due to a requisition order by the French Government. The suggestion that supply can simply be buttressed by having entrenched JIT contracts ignores the fact that urgent procurement takes place during a distressed marketplace where it will often be impossible for manufacturers and suppliers to fulfil the agreed order.

Distribution of the PIPP Stockpile

23. The WHO declared the novel coronavirus outbreak a global pandemic on 11 March 2020. Each nation held its own allocation of the stockpile with logistics also coordinated by the owning nation and decisions on how to use its proportion being made independently by the nation to which it had been assigned. In England, PHE first authorised SCCL, via Movianto, to distribute PPE from the English stockpile on 8 March 2020 on an ongoing basis. These releases were made to respond to a mismatch between supply and demand, alongside BAU demand management protocols introduced by SCCL on 3 March 2020.

24. As the first wave of COVID-19 approached, the Department decided to distribute centrally held stores of PPE, including the English stockpile, to supplement stock held by hospitals and care providers until additional supplies could be guaranteed. Existing BAU distribution routes were used to ensure, as far as possible, that supplies got to where they needed to go. The Department made direct deliveries to the NHS, facilitated one-off deliveries to GPs

[5] see First Corporate Statement of Jonathan Marron for Module 5, dated 16 December 2024, at [203]

and pharmacies and supported private wholesalers, through selling them PPE for onward distribution to ASC and other community-based providers (such as primary care, pharmacies etc.).

25. The NSDR Freight Team was also reactivated to work with the Armed Forces to compile emergency packs of PPE to be delivered to frontline health and social care facilities via DPD Logistics. The NSDR supported the delivery of 22.05 million items of PPE, including, Type IIR facemasks, aprons, and gloves in the first two weeks of March 2020.

26. As the Inquiry heard from Dame Emily Lawson,[6] there were initial warehousing and logistical challenges in early March 2020 as NHS Trusts prepared themselves for the pandemic. These challenges were a result of increased demand that pushed the limits of warehouse capacity to manage the intake and onward distribution of the PPE being delivered. As COVID-19 reached the UK, these challenges were further felt due to staff absences due to illness, lockdowns and shielding policies.

27. On 19 March 2020, a formal request was made with the authority of Emily Lawson, from NHSE, for military assistance. Major General Prosser gave evidence[7] about how these distribution challenges were quickly overcome, initially by the use of Armed Forces personnel. This led to increased capacity and supported the organisation of inbound and outbound stock at Movianto's warehouses and Unipart's distribution centres. This allowed for quicker distribution to the health and social care system. This initial task, which could have taken an estimated 4-6 weeks, was addressed within 1-2 weeks. This was achieved through existing logistical suppliers in addition to the additional capacity provided following the appointment of Clipper Logistics by SCCL. This appointment took place in response to an indication from Unipart Logistics that they were unable to scale up their logistical network in order to meet the demand which resulted from the pandemic and the need to urgently store and distribute PPE.

28. The Department would like to recognise and thank the Armed Forces, NHSE and Clipper Logistics who were instrumental in addressing these early challenges and speeding up the delivery of PPE to those who needed it most in hospitals and social care settings.

[6] Page 12 - PHT000000154
[7] Page 134 – 135 PHT000000163

VENTILATOR PROCUREMENT

29. The UK's ventilator procurement programme was undertaken as part of the broader COVID-19 response. It demonstrated several strengths, especially in terms of speed, adaptability, coordination, and resilience, despite operating in an unprecedented and high-pressure global environment.

30. In early 2020, there was significant uncertainty regarding the impact of hospital admissions on ventilator bed demand. In addition to this, ventilators were not required to be held in the PIPP stockpile. BAU NHS procurement routes, such as SCCL, struggled to cope with the increased demand as hospitals prepared themselves for the first wave of the pandemic. In response, the Department promptly launched a ventilator procurement programme on 3 March 2020 with procurement actions beginning immediately thereafter. This was known as the O2VMD&CC programme. The Department worked together with NHSE to collect and analyse data on ventilator demand, and to coordinate the distribution of ventilators.

Modelling

31. Ventilator modelling produced variable results between February and March 2020, with estimates ranging from 59,000 to 138,000 ventilator beds needed. The lack of scientific understanding of COVID-19, the speed of transmission and the impact it could have on hospital admissions made accurate modelling particularly difficult in the initial stages of the Department's response. When considered alongside the NHS's maximum surge ventilator capacity at that time (circa 7,000 beds for a maximum of two weeks) the Department had to rapidly establish a clear target and procure the necessary devices to save lives.

32. Modelling estimations and a target of 30,000 ventilators was established in early March. The Department initially utilised SCCL's existing framework-agreed suppliers through which the majority of contracts were awarded. This ensured the procurement of quality and cost-effective ventilators quickly; however, as this route became exhausted, the Department explored options from non-established suppliers and manufacturers.

Procurement and Assurance Mechanisms

33. Through their network of embassies, the FCO and DIT worked closely with the Department to identify new sources of international supply. The government's Call to Arms, led by then BEIS, attracted thousands of offers and unlocked additional supply channels, enabling procurement opportunities outside of traditional routes. Whilst in parallel, CO launched the

'Ventilator Challenge' with the objective of procuring additional ventilators, from non-established suppliers that could shift manufacturing capacity.

34. For contracts with new suppliers, the Department accepted the increased risks of overpaying, ventilators not being received, not being acceptable to NHS clinicians and/or arriving after peak UK demands. However, the primary consideration was always ensuring that the UK had as much ventilator capacity as possible in order to save lives. Decisions to award contracts were primarily steered by confidence and delivery risk, rather than price considerations, and all offers were subjected to the same assessment and recommendation process to support decision-making. This process[8] was:

    a. Models offered were compared against a list of known devices that had already been considered as acceptable, or unacceptable, by clinicians. If the device offered wasn't on either list, the specification would be sent for clinician review and then added to the appropriate list;
    b. The credibility of the offer was assessed, considering factors such as the nature of the supplier, the volumes, and proposed lead times, given location; and
    c. The commercial offer was considered, primarily in light of what premium was being sought for the devices over and above normal market value.

35. In the same way that Regulation 32 Public Contracts Regulations 2015 (PCR) was used in the context of PPE it was also applied to the purchase of ventilators to make direct awards of contracts, this was the correct and necessary approach.

Quality Assurance and Device Testing

36. Initially, NHS Trusts were requesting ventilators as quickly as possible to build capacity ahead of expected demand. Early in the pandemic there were some concerns about quality and safety concerns of some devices. The Department learned lessons throughout this process and increased its confidence in its ability to cope with demand, this led the Department to move to a 'test it then deliver it' model.

37. A structured, risk-based evaluation framework was developed incrementally and implemented for all new devices between March to April 2020. This included quarantine protocols, clinical and technical due diligence, ensuring patient safety despite the emergency context. Independent assessments were conducted by specialist centres,

[8] INQ000561670

including Medical Device Testing and Evaluation (MDTec) in Birmingham, and Queen's Medical Centre in Nottingham, with reference in evidence to over 92.5% of device spend being on devices which received favourable outcomes (outcomes 1 or 2)[9]. Devices that failed to meet standards were either modified, exchanged, or withdrawn.

38. This evaluation framework culminated in a report recommending one of four outcomes for each model of ventilator which would determine whether the devices would be released, remain in quarantine pending additional components or consumables, or not released. This structured approach ensured ventilators met clinical and technical requirements before being distributed to healthcare providers.

Distribution

39. The Department identified early in the pandemic that NHS warehousing facilities and logistics were unable to accommodate the increase in ventilator demand. The Department would like to recognise and thank the Ministry of Defence (MoD) who rapidly converted facilities in Donnington to track and receive incoming goods and support export and import control protocols, in addition to the framework evaluation of new products and the onward delivery of goods to Trusts.

40. In parallel, and at pace, the Department developed an allocation process that ensured devices were appropriately and fairly distributed (levelling disparities across regions), prioritising immediate medical need during surge periods and capacity building between surges. A clinically driven National Ventilator Allocation Panel (NVAP) was established to provide strategic direction and oversight of this allocation process.

Surplus Capacity

41. By mid-April 2020, the anticipated surge in demand had not materialised and by the second half of 2020, the UK had exceeded its target of having 30,000 ventilators with further deliveries expected[10]. This allowed the Department to consider donations to other countries without impacting UK capacity or resilience.

[9] Pages 23-24 - PHT000000157
[10] INQ000514230

PPE END-TO-END SUPPLY CHAIN

42. Inquiry expert evidence has suggested[11] special framework agreements ought to have been in place. The implication being that the existence of these framework agreements would both service a supply chain breakdown and perform in the event of a global PPE shortage. In fact, existing special frameworks did exist and continued to deliver vital PPE in the existing supplier stream of the Parallel Supply Chain, but their capacity limits were severely tested by the volume and price acceleration experienced in early 2020.

Initial Efforts to Continue Using Existing Framework Agreements

43. With the emergence of COVID-19, an international scramble for PPE began. Despite the best efforts of the NHS and SCCL procurement teams and individual wholesalers, it became increasingly clear that existing routes of procurement and distribution were unable to meet the demands of the health and social care system. Contracts agreed were not being fulfilled, delivery schedules slipped and private wholesalers reported being unable to source PPE for community and social care providers.

44. The Department's first response when the Cell was convened in February 2020[12,] was to support existing procurement routes, such as direct purchasing by NHS Trusts and maximising the use of SCCL's existing framework agreements. The Cell met daily to consider the products already within the SCCL network to support BAU procurement and regularly received updates on realistic, potential scenarios of the worst-case situation if the situation escalated. SCCL were repeatedly instructed by the Department to procure additional stock, initially focusing on six specific areas of requirement (body bags; clinical waste bags; Type IIR face masks; FFP3 respirator masks; general purpose detergent; and gowns) irrespective of modelling from NHSE".

45. SCCL were given delegated authority to place orders necessary for NHS supply without the need for direct approval from the Department. However, demand quickly outstripped SCCL's capacity to procure PPE via their framework agreements. Accordingly, the EU exit stockpile was released to augment SCCL's stock position, followed by mobilisation and deployment of England's PIPP stockpile. The Department's Chief Commercial Officer, on behalf of the Secretary of State, wrote to medical suppliers to conduct a full risk assessment of the impact of the situation on their supplier chains. By the end of February

[11] Page 24 - INQ000539153
[12] INQ000339268

2020, WHO acknowledged the acute global shortage of PPE and international exports of PPE from China were down 13-16% compared to 2019, despite increases in demand. As set out above, PHE activated the PIPP stockpile JIT contracts; however, ultimately, they failed to deliver due to inability of the contracted parties to deliver the PPE they had agreed to supply.

46. Demand transcended supply and despite the efforts of the Cell, SCCL and NHSE, by mid-March 2020, responding to global supply challenges required increasing innovation as existing infrastructure and contingency plans for the procurement and distribution of PPE could not cope.

The Parallel Supply Chain

47. Over the weekend of 21/22 March 2020, following cross-government discussions, it was decided that a centralised PPE procurement function was required in addition to, but outside of, SCCL's BAU procurement structure. This new function became known as the 'Parallel Supply Chain' and was led by the 'PPE Cell'.

48. The PPE Cell grew rapidly and whilst funding, decision-making and contracting authority remained within the Department, it was a huge collaboration between multiple organisations including NHSE, MoD, Armed Forces, FCO, BEIS and CO. Governance structures were in place as early as April 2020 and formalised over time, as the situation required initial responsiveness and fluidity.

49. The Department continued to prioritise the procurement of PPE through SCCL's established framework-agreed suppliers (known as the 'Existing Suppliers Team'); however, early modelling suggested this would be insufficient to meet demand for the RWCS. Therefore, alternative procurement routes were identified and prioritised:

    a. The 'China Buy Team' worked with the British Embassy Beijing to identify local opportunities from suppliers that were not already supplying the health and social care system. FCO's role pre-dated the creation of the Parallel Supply Chain; however, as the structures formalised, this team was formally integrated as a FCO and CO led team. This procurement route was initially prioritised as immediate deliveries could be fulfilled whilst UK manufacturing scaled-up;
    b. The 'Make Team' tasked with increasing the domestic manufacture of PPE in the UK. As UK manufacturing capacity grew and deliveries were starting to be fulfilled, the Department re-prioritised to this procurement route; and

c. The 'New Suppliers Team' triaged and processed the considerably large number of offers received predominantly through the 'Call to Arms'. These suppliers, in some instances, were not only new to the Department but new to the PPE industry too.

50. Not knowing the trajectory of the virus, how global markets would recover, whether non-pharmaceutical interventions (e.g., lockdowns, shielding, etc.) would be successful or when an approved pharmaceutical intervention (e.g., vaccines, therapeutics, etc.) would be medically approved; the Department acted pragmatically to ensure the UK had sufficient PPE to withstand not only the first wave of the pandemic but that it would be well prepared for a combined RWCS coronavirus and influenza outbreak during winter 20/21.

51. In total, an estimated 38.2 billion items of PPE costing £13.8 billion were procured. Of this, SCCL procured a total of 17.4 billion PPE items (45.4%) through contracts worth circa £5.2 billion (37.7%) and the Department procured a total of 20.8 billion PPE items (54.6%) through contracts worth circa £8.6 billion (62.3%). By 31 March 2022, when operational responsibilities for PPE were returned to SCCL, the Department had distributed 19.8 billion items to health and care providers to help keep staff and patients safe throughout the pandemic. When the provision of free PPE ended on 31 March 2024, over 27.1 billion items had been distributed.

The "Call to Arms"

52. The Inquiry heard evidence from numerous witnesses regarding the volume of offers received by Parallel Supply Chain, including those in response to the Call to Arms which eventually reached circa 24,000 offers from over 15,000 suppliers.

53. The Department recognises the immense amount of work completed by the New Suppliers Team. As Jonathan Marron stated in his oral evidence,[13] the Call to Arms resulted in an incredibly large number of offers being received; this led to the Department sourcing valuable PPE that it would not have otherwise been able to through unknown contacts within PPE manufacturing. The work of the New Supplier Team and the PPE procured via these contracts could have been the difference between a frontline health and social care worker receiving the PPE they needed or not. The Department's view is that the Call to Arms was a worthwhile endeavour and would like to acknowledge all those who responded to the public call, whether that be in the making or processing of an offer.

[13] Page 171 - PHT000000151

54. Following the initial launch of the Call to Arms, the application form was amended with a stricter criterion to limit the number of non-viable offers being received. The Department agrees with the view expressed by the Chair[14], namely that it was difficult to set the bar in determining those who could make an offer to supply PPE. There is a balance to be struck between ensuring credible offers are received and that there is not a deluge of offers which have no prospect of supplying meaningful quantities of PPE as Mr Marron confirmed during his evidence.

The 8-Step Assurance Process

55. The Department was mindful of the urgency to procure PPE which met the technical and quality needs of the NHS and wider health and care system and the need to spend public money wisely, identifying viable opportunities to progress to contract whilst avoiding engaging with those seeking to defraud the country. Accordingly, an 8-step process was used in progressing an offer.

a. Initial Data Collection: Collecting basic data about potential suppliers through the Coronavirus Support from Business Scheme portal, including company details and product offerings;
b. Identifying Viable Opportunities and Triaging: Prioritizing offers based on company size, volume of products, and urgency of need;
c. Validate Opportunities: Assessing offers in detail, including technical documentation and initial pricing estimates;
d. Commercial Due Diligence: Conducting financial and commercial checks on suppliers using tools like SPOTLIGHT and external services like Contingent;
e. Confirmation of Technical Review: Reviewing product specifications and compliance with regulatory standards;
f. Close Terms and Conditions and Pricing: Negotiating terms and conditions, pricing, and administrative details with suppliers.
g. Complete Approval Documentation: Compiling submission packs with all necessary documents for review; and
h. Sending to the Department for Approval: Final decision-making by the Department's Accounting Officers ("AO"), assessing regularity, propriety, value for money and feasibility of the proposed contracts.

[14] Page 169 - PHT000000151

56. The Department stands by this process of progressing an offer and it is unclear how otherwise sufficiently detailed information could have been provided to an AO, in order for them to make a decision balancing risk and opportunity to authorise spending public money. The workflow set out by the end-to-end process maps used by the buying teams to process the 8-step process, whilst portrayed by those inexperienced in commercial activities to the inquiry as complex, represents standard and understandable progression of an offer, with clear hand-offs between teams with responsibilities for each stage in the process.

57. The use of rapid due diligence processes with a 4-hour turnaround and the involvement of experienced technical assurance teams from the MoD helped expedite the process.

58. The AO, who authorised contract formation, at all times assessed offers impartially and consistently with the tests inherent within the assurance process. As Chris Young confirmed in evidence to the Inquiry,[15] it did not matter where a deal had been referred from, what mattered was that the appropriate assurances that came within the first seven stages had been undertaken, and the deal was being recommended on the basis of it being a sound deal.

Use of Intermediaries

59. The Department was operating in a, predominantly, intermediary-led market which it had no previous commercial experience in. Wholesalers and SCCL being two examples of intermediaries. Therefore, it was a reasonable approach to initially explore and secure contracts via intermediaries, familiar to the UK Government, who had a better understanding of the global PPE market and the logistics of delivering PPE to the UK and it was understood that this expertise could come at a higher cost. To ensure the UK had sufficient PPE, the Department also considered viable offers from new intermediaries as well. Where appropriate and not otherwise engaged with through an intermediary, the Department sought to contract directly with manufacturers.

60. Centralising procurement and supply within the Parallel Supply Chain had the benefit of reducing conflict between UK-based buyers and competition between intermediaries selling PPE. For example, FCO managed a list of China-based manufacturers the Parallel Supply Chain was already working with, to prevent intermediaries from trying to sell access to the same PPE which the UK was already in the process of buying (either directly or via

[15] Page 29 - PHT000000162

alternative intermediaries). The NHS, ASC providers or Devolved Governments were always permitted to make their own attempts to buy PPE; given the supply challenges it would not have been feasible to achieve full centralisation. The market price during this period was set by the international scramble for PPE in which UK buyers were not the sole participants. By June 2020, as compared with prices in the final quarter of 2019, the price of FFP2 respirators had risen by 411%, gowns by 295%, gloves by 288% and aprons by 172%.

The High-Priority Lane (HPL)

61. The Department accepts the findings of the 'R. (GLP and EveryDoctor) v SSHSC and Crisp Websites and others [2022] EWHC 46' which found the HPL to be unlawful, noting that the finding was limited to transparency and that the contracts would have been awarded in any event. We note that case found that the test cases being scrutinised would have been prioritised on the basis of the volume of vital PPE being offered. A review of the PPE Contracts Table provided to the Inquiry, by the Department, aligns with this, with large volumes of critical PPE being ordered which would have been prioritised irrespective of route of referral.

62. The Inquiry has heard conflicting evidence whether an offer was progressed more quickly if it entered via the HPL rather than other routes. There is clear evidence that all offers went through the same 8-step process. The only stage at which there was a different approach was during the initial information gathering stage; there was no prioritisation in respect of due diligence, technical assessment or in closing and approval. It is clear from the evidence of those who worked on the HPL that they saw value in the volume of PPE they were sourcing and worked as quickly as they could to move offers through the system. The evidence of the AOs has shown that they treated HPL cases in the same way as any other case, as Chris Young stated the HPL was "*not a specific matter that any of the accounting officers concerned themselves with*".[16]

63. The role of the HPL was to triage offers and refer them to the assurance stage, an HPL offer underwent the same 8-step procurement assurance process as any other offer. There is no written or oral evidence from Cabinet Office or the Department before the Inquiry to suggest that government relationships played any part in contract awards or have any effect on the assurance process. The Department's experience was that the offers that

[16] Page 29 - PHT000000162

reached the HPL tended to be from larger commercial suppliers making viable offers coupled with the means to deliver. The concept of 'Ministerial Oversight' is not unusual, as Max Cairnduff explained, it would not be appropriate to give a Minister an automated response if they were concerned that an opportunity had been missed.

64. Jonathan Marron explained during his evidence that the perception that there was a channel which meant "*some people could go quicker... has been extraordinarily damaging to the reputation of the programme*". The perception was driven by the name of the HPL rather than any structural advantage that was afforded by entry into the HPL. The Department has adopted those recommendations made by the Boardman review in respect of the approach taken.

65. Nevertheless, it was rational to have a mechanism to handle ministerial and parliamentary referrals and evidence the Inquiry has heard from ex-ministers that, in the event of a future pandemic, their successors would be similarly inundated with approaches of offers of support which would need to be forwarded to those handling the commercial response.

66. One of the key learnings for the Department is the need, at times of supply chain distress, to maintain confidence in our ability to deliver. Anything that undermined that confidence should not be repeated. The Department would suggest that the functions of the HPL would be better handled in a future event by larger administrative support to those buying supplies, so that those buying are not directly contacted by those passing on offers and by the use of better Customer Relationship Management (CRM) systems and automation which would allow live tracking of an offer through the contracting process.

67. Below is a comparison of HPL vs non-HPL contracts awarded and their subsequent performance:

	HPL	**Non-HPL**	**Total**
No. of suppliers that offered PPE	~430	15,194	15,624
No. of suppliers awarded a contract	52	172	224
% of suppliers awarded contracts	12.09%	1.13%	1.43%
Original spend of DHSC awarded contracts	£4,218,613,447	£4,407,754,658	£8,626,368,106
Original quantity of PPE agreed	7,807,158,256	13,094,355,732	20,901,513,988

No. of contracts awarded	117	277	394
No. of contracts within [DN: INQxx (new table)] that:			
Were awarded directly to a manufacturer	13	73	86
Had a conflict of interest declared by the supplier	8	1	9
Involved pre-payments being made	96	161	257
Used standard government terms and conditions	97	162	259
Were placed in DNS due to contractual performance issues	64	101	165
Of the 165 contracts placed in DNS, contracts were found to be met and product released following:			
Secondary assurance review	8	13	21
New documentation	13	28	41
Of the no. of contracts placed in DNS, contracts were found to be met; however, products were not released due to:			
NHS choose not to use	3	12	15
Stock expired	7	2	9
Stock cannot be used	3	15	18
Of the remaining 61 contracts in DNS found to have not been met following a secondary assurance review:			
Resolved without waiving or abandoning claims	11	2	13
Resolved with a percentage of claims against the contract being waived or abandoned	7	8	15
Claims entirely waived or abandoned	8	16	24
Remain in dispute	4	5	9

Record Management

68. Due to the unprecedented nature and urgency of the pandemic, staff progressing offers were predominantly home-based and communicated with suppliers via telephone and by email. The information gathered was initially recorded in Excel spreadsheets in the first couple of weeks of the effort until early April 2020, and thereafter within the Mendix case management system. The Mendix system allowed caseworkers to track offers through the procurement lifecycle. Subsequently, to support the Department in doing so, information relating to awarded contracts was later transferred from Mendix to the Department's contract management system, Atamis. Each government department is responsible for selecting its own data management system.

69. The Department recognises and accepts that data management in progressing offers, in the circumstances it found itself in in early 2020, required improvement and this is reflected in the improvements that occurred in response to that challenge as the effort matured through April 2020. That these issues did not derail the efforts of the programme to effectively source PPE is a testament to the hard work and professionalism of the caseworkers within the Parallel Supply Chain.

The Department's Use of Regulation 32 and Direct Awards

70. Procurement Note (PPN) 01/20 was issued on 18 March 2020 and described the range of commercial actions to be considered by contracting authorities in responding to the impact of COVID-19. It emphasised that, given the exceptional circumstances of the COVID-19 pandemic, contracting authorities may need to procure goods, services and works with extreme urgency. Utilising Regulation 32 Public Contracts Regulations 2015 (PCR) to make direct awards of contracts was both necessary and a sound and measured approach to take. This was subsequently updated by PPN 01/21 which provided further details on when it was appropriate to use Regulation 32(2)(c) PCR.

71. These Procurement Notes confirmed that the Department was entitled to use direct awards through Regulation 32(2)(c) PCR where the Department was able to prove that all the tests set out in Regulation 32(2)(c) PCR (and reiterated in PPN 01/20) were met. The Department, where these tests were met, was then able to make direct awards of contracts to procure PPE, facilitating a quicker distribution of these products to frontline staff.

72. PPN 01/20 provided the following options for procurement given the extreme urgency of the pandemic:

a. Direct awards under Regulation 32 PCR 2015, due to extreme urgency, or due to absence of competition or protection of exclusive rights;
b. Call offs from an existing framework agreement or dynamic purchasing system;
c. Calls for competition using a standard procedure with accelerated timescales; and
d. Extending or modifying contracts during their term in compliance with Regulation 72 PCR.

73. This was a sound and measured approach to take. The inquiry has heard evidence that the Parallel Supply Chain prioritised call-offs for PPE from existing frameworks using SCCL's Existing Supplier's Team where possible alongside direct awards to new suppliers.[17]

74. Regulation 32 PCR was a critical tool for emergency procurement during the pandemic, enabling rapid responses to urgent needs. Regulation 32 PCR was utilised within the Ventilator Challenge as the UK market had largely exhausted the supply of components utilised in ventilator manufacture. The components utilised by UK manufacturers were by and large sourced from foreign markets and the supply chains for those components were distressed. It followed, inexorably, that a UK based programme needed to be developed urgently.

Contract Award Notices (CANs)

75. The Department recognises the importance of transparency when contracts are made and the interpretation of the legal requirement to do so was clarified by the findings of 'R. (Good Law Project Ltd) v Secretary of State for Health and Social Care [2021] EWHC 346 (Admin)'; however, the nature of the pandemic gave rise to urgent and lifesaving work. It is understandable in those circumstances that staff prioritised the procurement of PPE over the contemporaneous publication of CANs. Particularly given that the same staff responsible for publication were engaged in the urgent procurement of PPE. Looking forward, we note that the Procurement Act 2023 requires that a transparency notice be served for direct awards; this notice must be published before a directly award contract is awarded and is in addition to the requirement to publish a contract details notice following the contract award. The contract details notice has the same effect as CANs under the repealed PCR. In the event of a future pandemic, those undertaking commercial activities will need to have administrative support to allow them to meet these transparency requirements. The presence of a modern case management system, such as that used

[17] Page 142 - PHT000000152

now by the NHS/SCCL would allow information to be easily collected whilst mitigating case worker time needed.

76. We note Transparency International's report raised by the UK Anti-Corruption Coalition included research to compare procurement across the EU using CANs. We are wary of the conclusions made. The underlying literature which was quoted provides caveats on its own methodological limitations. There are significant uncertainties about whether contracting authorities in other Nations were transparent in publishing contracts they had entered, irrespective of the requirement to do so. Policy context is also absent; EU nations have differing approaches to the provision and funding of health and care and approached the procurement of PPE in different ways during the pandemic. It is unclear to what extent these health and care systems feel an obligation to publish contract notices especially where they may be below the threshold value for publication. The paper does show that the UK was not an outlier in the predominant use of direct awards, being clustered with peer-nations such as France, Germany, Spain, Portugal, Austria and EU procurement itself. The approach taken ignores key issues such as the use of third-party contractors in other European States and the different approach taken to the publication of contract notices. The Department adopts the observations made by Christopher Hall in his fourth witness statement dated 3 April 2025[18].

EU Joint Procurement Activities

77. We also note the ongoing interest in the EU's joint procurement activities (JPA) for clinical consumables. We reiterate that non-participation in the JPA was not a deliberate act by the UK Government. Rather, we were not informed by the EU in time to participate. That said, it is evident that the JPA failed to deliver significant timely volumes of PPE. This was supported by an Inquiry Expert who stated that *"the first call to market was not successful and they had to stop it*", thus demonstrating the clear downside of participation.[19] No comparable EU peer nation bought PPE from the JPA irrespective of their initial participation indicating they made alternative arrangements to buy PPE in the market.

CAPTURING DATA AND MODELLING

[18] INQ000587257
[19] Page 6 - PHT000000150

78. There were several challenges associated with the modelling methods employed to forecast PPE demand. The initial challenges included:

    a. The absence of any similar prior experience to rely on, i.e. an absence of epidemiological and virus transmission data;
    b. The need for growth in understanding of the systems;
    c. A recognition of pauci-symptomatic or asymptomatic transmission;
    d. The need to have available PPE for all healthcare interactions whether directly related to COVID-19 or not;
    e. The fact that BAU interactions had been affected; and
    f. The risk that contracts would not be fulfilled or result in product being received that was not fit for purpose.

79. It followed that a model-based approach was necessary. The model relied on best estimates of COVID-19 cases and of the PPE demand in healthcare settings, as per IPC (Infection Prevention and Control) guidance.

80. By April 2020, a stable demand model was available, though refinements continued. The model showed significant increases in PPE needs compared to pandemic influenza planning, e.g., aprons (+820%), gloves (+388%), and face masks (+125%). Demand patterns varied; gloves usage remained steady, whereas FFP3 masks tracked COVID-19 caseload fluctuations.

81. A number of demand modelling types were utilised, including a 'Daily PPE Dashboard', tracking of stock levels, shipments, shortages, and guided daily decision-making. A PPE 'Ready Reckoner' provided a short-term (7-day) forecast of PPE needs for 250 Trusts in England. A PPE Inventory Model offered a 90-day view of stock levels and projected demand, helping procurement teams to prioritise purchases.

82. These models informed high-level government decisions, including financial allocations and lockdown relaxation measures. By mid-2020, PPE planning was integrated into industry-standard supply models, with demand projections aligned to NHS activity and expected surges. Modelled demand fluctuated significantly between February and May 2020, due to the impacts of lockdowns and test-and-trace data, changes to IPC guidance and greater understanding of COVID-19 transmission and the measures needed to mitigate it. A Reasonable Worst-Case Scenario (RWCS) was used to guide purchasing targets while data improved. A mathematical model is only as accurate as its input

variables. RWCS approaches utilise conservative estimates of the different input variables. The resulting model then relies on an array of conservative estimates.

83. A buying target based on this approach aimed to ensure higher quantities of PPE than necessary. This was in line with direction from the Prime Minister and Ministers.

84. The Department bought to the target set and was successful in doing so. Demand over the first wave was flattened by the impact of lockdown, but overall usage for PPE remained high throughout the pandemic reflecting both COVID-19 case rates and BAU NHS activity. By 31 March 2024, 27.1 billion of the 38.2 billion items bought were distributed. RWCS modelling factored for the slower development of a COVID-19 vaccine and had one not been developed so quickly, it is likely that all the PPE bought would have been used and indeed we would have gone to market to buy more PPE. The Department stands by that approach, it being preferable to have procured on a RWCS basis than to have run short of PPE and the concomitant effect that would have resulted from that approach, not least that a failure to procure enough PPE would have led to delays in reopening from lockdown in spring 2020 with the associated economic impact. Although buying based on the RWCS led to a large excess of PPE, this was far preferable than the alternative.

QUALITY ASSURANCE, DEVICE TESTING AND DISTRIBUTION

85. The Department recognised the risk of purchasing PPE from new suppliers and the pressure on purchasing at pace, border closures and lockdowns meant that there was little opportunity to check the PPE or material beforehand, which is considered BAU best practice. Another consideration in deciding how much PPE should be purchased was whether all contracts would be fulfilled entirely.

86. There was a view that, on average across all PPE contracts with new suppliers, an estimated 10% of contracts would not be fulfilled and a further estimated 10% of contracts would result in product being received that was not fit for purpose. This risk was accepted by the Department and with the additional consideration that these contracts were awarded based solely on the technical assurance of documentation, the Department appropriately took a cautious approach to quality assurance when product reached the UK.

87. A key step in the Parallel Supply Chain process involved reviewing technical certificates against the product received to ensure its quality before being distributed. The

Department's aim was to quickly distribute compliant PPE to end users, prioritising product types most in demand and they are not aware of any delays to deliveries or supply of PPE resulting from the quality assurance process set out above. Refinements to the technical assurance process ensured that any item received at the Daventry warehouse was available to pick immediately and categorised for use, using improved quality assurance and quality control speeding up the validation of products.

88. Where a concern was raised over compliance, that batch of product was held back from onward distribution until the Parallel Supply Chain's Technical and Regulatory Assurance Team reviewed a sample of each product. It was temporarily placed in a 'Do Not Supply' (DNS) category until this further assurance work could be completed. This additional assurance work and the remediation of underperforming contracts was completed by the Department's Dissolution Team which was established in April 2022 in order to formalise the work that was already underway.

89. During the hearings, the Inquiry highlighted that 165 of the contracts detailed in INQ000575086 were originally placed in DNS. This is correct for the number of contracts initially identified as DNS; however, this number does not reflect contracts that were later found to have been met following secondary assurance checks. This information is summarised below:

Number of Contracts Removed from DNS	Running Total of DNS Contracts
Product received from 165 contracts was originally placed in DNS.	
21 contracts met and product was released without further action.	144
41 contracts met and product was released following receipt of new documentation.	103
15 contracts met but the NHS choose not to use the product.	88
9 contracts were met but stock expired whilst in DNS.	79
18 contracts met but cannot be used. An example of this could be product bought at the end of March 2020 that no longer complied with updated technical specifications published in April 2020.	61
13 contracts not met but were resolved through securing new product, recovering cash and/or negotiating savings without the need for waiving or abandoning claims.	48

15 contracts not met but were partially resolved through securing new product, recovering cash and/or negotiating savings. The outstanding claim was then waived or abandoned.	33
24 contracts not met and claims were waived or abandoned.	9
9 contracts are in dispute and the product remains in DNS.	

90. As can be seen from the table above, 61 contracts were not met which equates to ~16.3% of contracts being deemed not fit for purpose as compared with the 20% expected by the Department. In part this was due to the robustness of the 8-step process in mitigating purchase of substandard equipment. Of the remaining 61 contracts, a further 13 were resolved in ways that ensured value for taxpayer money which leaves ~12.8% of contracts that remain in dispute or were resolved in ways that included claims being waived or abandoned.

91. The Department has produced its own analysis of the PPE contracts awarded by the Department (excluding SCCL's framework-agreed contracts) during the pandemic. This can be found at [DN: INQxx (table analysis)].

92. The Parallel Supply Chain developed strong customer-focused engagement plans with end-users to allow issues to be reported and investigated as they arose. Whilst the Department recognises that occasional quality issues occurred with the product bought, it is felt, however, that media coverage exacerbated the damage to public and end-user confidence.

PPE Distribution

93. The early challenges relating to the warehousing and distribution of PPE in the PIPP stockpile included the fact that products were held in deep storage and with insufficient staff numbers to ensure ready access. This was addressed by the Armed Forces, initially, and the later appointment of Clipper Logistics; however, further inbound and outbound challenges persisted as the PPE Cell and Parallel Supply Chain took responsibility for procuring PPE for all health and social care settings across UK.

94. Major General Prosser, in his evidence, explained the operational pressure that was felt across the end-to-end procurement as a result of establishing a new supply chain, a new supplier base and a lack of sight for when PPE was being delivered to Daventry. This was a challenge of the time, and the circumstances presented by the pandemic and a pragmatic approach was taken to managing the impact that this had on the distribution

system. The MOD was able to draw on their reservists which led to two logistical experts collaborating with Lieutenant Colonel Dutton at Daventry to provide a disciplined tempo, diversity of thought and resilience. Their clear communication of what was happening at Daventry was crucial in supporting the rest of the distribution system.

95. The outbound supply chain in place prior to the pandemic, which SCCL continued to use, was only designed to accommodate delivery to 226 National Health Service Trusts. By August 2020, with the establishment of the Department's parallel distribution system, essential PPE was supplied to 58,000 different settings, including care homes, hospices and community care organisations. This was achieved, with the support of MoD and the Armed Forces, through the establishment of a distribution network to warehouse, sort and distribute PPE across the country.

96. The opening remarks of counsel to the Inquiry acknowledged the challenge of ensuring the NHS received the type of PPE products they required. There was considerable difficulty due to a lack of available data. Initially, deliveries were based on predicted demand using RWCS for cases of COVID-19, from SAGE, and the Department's understanding of how much PPE would be required in those scenarios. Following the introduction of situational reports from NHS Trusts, a Ready Reckoner model was used to translate that data into PPE requirements across those products with acute shortages. These formed the sole basis of the PPE pick lists for Trusts.

97. By 10 April 2020, recognising that the push-model was an imperfect tool, the delivery system evolved into a hybrid between modelled-push and demand-pull distribution. In addition to the Ready Reckoner model, specific requests for stock were also considered. These improved over time as more data became available and the approach was refined to consider stakeholder adjustment (stakeholders could manually adjust the pick list), outcomes of daily pick list meetings (impact of proposed issues on stocks were considered) and from May 2020, system learning (an algorithm introduced to adjust future pick lists based on stakeholder's previous manual adjustments). Ultimately, PPE supply was embedded within the NHS's inventory management system, allowing PPE to be distributed to maintain an NHS Trust's stock of PPE dynamically.

98. Recognising that additional support was also needed to meet the diverse requirements of social care, a network of Local Resilience Forums (LRFs) was engaged to create a further temporary emergency channel of supply and to coordinate the response to local issues. LRFs functioned as hubs for receiving PPE for onward distribution, at no cost, to social care and other services that could not access PPE supplies in other ways. Logistical

challenges persisted and as heard in evidence from Helen Whately MP, pressure on LRFs was growing and straining their relationships across local government and with end-providers.[20] As a result of this, the Department established an e-Portal, which was piloted by 9 April 2020, with eBay, Clipper Logistics, Royal Mail, NHS, Volo, and Unipart. After the pilot period the roll-out progressed with 22,000 eligible GPs and smaller ASC providers registering by 26 June 2020 and all community and care settings being granted access by September 2020. The e-Portal remained in place until 31 March 2024[21].

99. The e-Portal innovation was an immensely important addition to the tools used to distribute PPE; it is held ready for future deployment in the event it is needed. The e-Portal allowed simple access into the system to express the demand for what was needed and provided PPE at speed where required. As a useful side-effect, the e-Portal increased the knowledge base for demand which was also of assistance in modelling.

100. The approach taken by the Department was a pragmatic one to resolving an enormous distribution challenge. It rapidly established a new distribution network from scratch for over 25,000 devolved social care providers and provided free PPE to the sector until the e-Portal was closed down.

101. It was better for PPE to be in the hands of end users, rather than sat in storage as the first wave approached. At this time, the purchasing was not done for stockpiling it was for direct distribution. Purchasing for the purpose of building up stocks did not start until September 2020. It should be noted that the Department's experience that they did not centrally 'stock-out' of PPE (although they came very close to doing so) is not inconsistent with frontline workers experiences of shortages. The Department was delivering "*to the door*" of providers who were then responsible for onward distribution and management of PPE for their staff. There may well have been distribution challenges outside the control of the Parallel Supply Chain, and it was entirely reasonable given the relationship between employees and employers, grounded in health and safety legislation, that local responsibility for PPE distribution be retained by individual providers. The complexity of such local storage and distribution arrangements were set out by Julian Kelly during the hearings, for example a Manchester-based Trust opted for a central warehouse that will have provided more storage and allowed them more space to work out how they distributed PPE to their individual sites.[22]

[20] Page 31 - PHT000000156
[21] JM/500 - INQ000000000
[22] Page 154 - PHT000000154

102. Between 25 February 2020 and 31 March 2022, 19.8 billion items were distributed to the health and social care sector. With regards to the distribution channels described above, the Department distributed:[23]

Distribution Channel	Total Number of Items of PPE from 25 February 2020 to 31 March 2022, at least
LRFs	337 million
Local Authorities	187 million
Wholesalers Serving GPs	40 million
Wholesalers Serving ASC	258 million
Wholesalers Serving Community Pharmacies	1.2 million
Wholesalers Serving Dentists	38 million
Wholesalers Total	337.2 million
e-Portal	6.92 billion

LESSONS LEARNED, POST-PANDEMIC PREPAREDNESS AND FUTURE RESILIENCE

Post-Pandemic Preparedness: PPE

103. Lessons learned exercises such as the Boardman Review, the 'Supply of PPE During the COVID-19 Pandemic' report (dated 25 November 2020) and the 'Management of PPE Contracts' report (dated 30 March 2022) have supported significant learning to enable better preparedness and responses to the pandemic.

104. A summary of updates linked to recommendations sent to PAC from the Department are Annexed.

Roles and Responsibilities

105. The Department remains responsible for ensuring the health and ASC system has access to PPE in the event of a future pandemic to ensure that the workforce is protected, such that essential health and care service functions can continue to be delivered and that the spread of infection in health and care settings is reduced. Much like its pre-pandemic approach, the Department maintains a stockpile of PPE to cover the early weeks of a potential pandemic until further stock is expected to arrive. However, the stockpile contents

[23] INQ000235007

and volumes have now been updated to reflect clinical advice for various transmission risk scenarios. In addition, the Department's approach now considers alternative contractual arrangements and modelling data.

106. SCCL remains responsible for the procurement and management of pandemic preparedness PPE, which was set out in Schedule 11 of a Service Level Agreement between the Department and SCCL, signed in April 2023.[24] The Department's 'Pandemic Preparedness Team' is now responsible for working directly with SCCL to manage procurement of PPE for pandemic preparedness purposes, and to instruct regarding activation and deployment of PPE, if required. UKHSA, formerly PHE, is no longer involved in the procurement or management of pandemic preparedness PPE stock. This decision was taken following a recommendation by Governance and Management sub-group of the Department's Review of Emergency Clinical Countermeasures in April 2022.[25]

Governance Structures

107. Future pandemic preparedness work is being carried out under the leadership of the Civil Contingencies Secretariat and the Department, who co-chair the cross-government Pandemic Diseases Capabilities Board.

108. The Pandemic Preparedness Portfolio (PPP) Delivery Board, established in November 2023,[26] is chaired by the Director of Emergency Preparedness and Health Protection and has responsibility for assuring delivery of the PPP, of which PPE is one workstream. The PPP Delivery Board reports into the PPP Strategy Board, chaired by the Director-General for Global and Public Health, which provides oversight of the strategic approach to pandemic preparedness across the health and social care sector.

109. In February 2024, the Department established the Clinical Countermeasures Policy and Programme Board (CCMPPB), which reports into the PPP Delivery Board. The CCMPPB sets the strategic direction for, and assures delivery of, clinical countermeasures programmes and policies to build UK resilience to pandemics and emerging infectious disease (EID) outbreaks. The scope of the CCMPPB includes PPE and is chaired by the Department's Deputy Director for UK Health Security, part of the Emergency

[24] JM/637 - INQ000496880
[25] JM/638 - INQ000496875
[26] JM/639 - INQ000496890

Preparedness and Health Protection Directorate. The Board has met five times up to April 2025[27] .

110. The CCMB, chaired by UKHSA, previously reported into the PIPP Board, and now reports into the CCMPPB and UKHSA's Centre for Pandemic Preparedness Oversight Board. The CCMB continues to provide governance and oversight on the use of vaccines and medicines as countermeasures in response to a pandemic. Since the pandemic, PPE procurement and policy is out of scope of the CCMB, and responsibility has been transferred from UKHSA to the Department.

111. The monthly Personal Protective Equipment Working Group (PPEWG) was established in November 2024 to review and inform policy development and implementation for PPE and hygiene consumables for pandemic preparedness purposes. The group is chaired by the Department. The PPEWG is a governance forum for pandemic preparedness PPE planning, and reports to the CCMPPB.

112. The Department has quarterly senior business review meetings with SCCL to provide oversight and seek assurances of SCCL's effective management of the PPE and hygiene consumable pandemic stockpile.

PPP Clinical Countermeasures Stockpiles

113. In 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 and not only influenza. The five transmission routes include:

a. Respiratory;
b. Touch;
c. Sexual/blood;
d. Oral; and
e. Vector.

114. Although the Department is preparing for a wider range of possible future pandemics, it is not possible to know the precise nature of any future pandemic. Data collected during the COVID-19 pandemic allows us to consider the volume of items requested and used at

[27] JM/640 - INQ000496886

each stage and has been used to calculate estimated requirements in the early weeks of any future pandemic. The Department's modelling of PPE requirements in the health and social care sector, in the early weeks of a future pandemic, uses PPE distribution data during the winter 2020-21 period as an indicator of demand or need. This has been combined with clinical advice on PPE products[28] required in different pandemic scenarios as set out in the draft 'Review of Emergency Preparedness Countermeasures Report' of 12 December 2023[29] .

115. As of January 2025, the Department's pandemic preparedness stockpiles contained a total of circa 2.2 billion items of PPE for the health and social care sector in England, compared to the 323 million held on 9 October 2019. This total includes equipment purchased as part of the Department's emergency procurement during the pandemic.

116. At the start of the pandemic, there were only four different types of FFP3 respirator mask; at the end of the pandemic there were twelve different types. As part of the planning being undertaken to support future procurements to reach and maintain the stockpile target of FFP3s, consideration is being given to ensure that there is sizing and fitting suitable to meet the needs of all of the health and ASC workforce.

Future Policy Development

117. Policy development on PPE as part of the Department's PPP is ongoing and is based on lessons learned and the findings of a Departmental 'Review of Emergency Preparedness Countermeasures'. As a result of this review, the Department's policy development is also considering the impact of the pandemic on fragile global supply chains, the potential to stand up UK manufacturing in an outbreak, and the demand for products observed in a respiratory pandemic with asymptomatic transmission.

118. Additionally, the Department is incorporating lessons identified from COVID-19 into its longer-term strategy for pandemic preparedness clinical countermeasures. This has included the dynamic rotation of stockpiled PPE and hygiene consumables for sale to NHS Trusts wherever possible. In 2024/25, 581m stockpiled gloves were sold to the NHS and replenished. This will reduce waste by reducing the need to dispose of expired stock and replace it with new stock, which also represents better value for money. In addition to dynamic rotation, the Department recognises the importance of alternative contractual

[28] JM/644 - INQ000496884
[29] JM/645 - INQ000496888

arrangements, how to incentivise UK manufacturing, and other innovative options such as reusable PPE.

Post Pandemic Preparedness: Ventilators

119. The Department's view is that although having a large physical stockpile of ventilators increases short term resilience of the system, there are several considerations to be made:

a. Storage, maintenance and administration costs;
b. Depreciation of product value and Warranty Expiry;
c. Recall and logistical movement cost;
d. Training on use of stockpiled machines, and
e. Disposal and/or replacement of products.

120. With these additional factors in mind, it is the Department's view that a range of stockpile models should be considered, such as stock held on hand by manufacturers for call forward as part of an ongoing contract, having preferred bidders and/or activatable JIT contracts. There are risks associated with both physical stockpiles and sleeper contracts (JIT contracts). For example, the Department experienced some issues with JIT contracts for PPE, such as suppliers being restricted by export controls under emergency circumstances, which can prevent contracts being fulfilled and ventilators being delivered to the UK. Emphasising supply chain resilience, understanding the system through data and modelling, and having the ability to scale-up rapidly will be essential to ensure better preparedness for a future pandemic.

Supply Chain Resilience

121. The Department recognises that ensuring end users had sufficient supplies of PPE during the pandemic was a significant and demanding challenge, which required a strategic and sustained effort. As set out in the Second Witness Statement of Stephen Oldfield,[30] then Chief Commercial Officer in the Department:

"*Global Supply Chains in health are typically long, complex, relatively inflexible and thus inherently fragile. They can be disrupted at any time by one or more "shocks" which can be environmental, economic, technological, logistical or political in nature. Ultimately, supply chain resilience is dependent on the strength of the entire supply chain and*

[30] INQ000534959

disruption in one or more of its parts [...] can have catastrophic consequences on the whole chain".

122. As the Inquiry has heard from several witnesses, prior to the pandemic, there was no centralised system to provide PPE to social care or NHS primary care providers. The devolved nature of procurement and logistics meant there was no centralised information on supply resilience in the NHS for PPE or ventilators at the point the pandemic emerged. For community providers, including adult social care and GPs, private wholesalers were the main source of PPE. There was also virtually no UK production at the time and all our buying efforts were directed overseas, predominantly through intermediaries. Therefore, no relationship existed with these overseas manufacturers.

123. The Department maintains that it should not aim to have to take over the procurement process of PPE or ventilators for future emergencies as it does not consider that it is best placed to deliver this centralised approach. In handing back the responsibility of procurement and distribution to SCCL, the Department transferred the responsibility of applying lessons learned in supply chain resilience to SCCL. The Department sought to provide significant support to embed supply chain management best practice and lessons learned from the Parallel Supply Chain into SCCL, and by March 2022 the Department had confidence that SCCL had developed their procurement and distribution processes to manage future PPE supply, including scaling up to meet demand resulting from a pandemic (as set out in the memorandum of understanding signed in April 2022) and operational control of PPE supply was transferred.

124. The Department used its increased capabilities to make good use of industry standard commercial practices around sales and operations, drawing on expertise from senior commercial leaders to look at the effectiveness of future modelling. The PPE Cell Sales and Operational Planning (S&OP) Director of Demand delivered a 'Commercial Practices in PPE Procurement' presentation to the Department's Analytical Community in late 2021 to explore how future modelling capability can potentially be improved using S&OP processes.

125. The monitoring of medical supply chains, including PPE has been built into the Department's structure by establishing the Supply Resilience Directorate (SRD) in May 2020. The role of the SRD is to ensure continuity of supply of medical products and promote long term supply chain resilience. SRD engages closely across different supply chains, including with trade associations, suppliers and manufacturers of medicines and medical products, and logistics providers. SRD utilises intelligence to model potential

supply disruptions, gather relevant data, track risks and impacts, and implement mitigation stratagems where necessary. A priority activity of the SRD is to support supply resilience internationally.

126. The Department expanded analytical and resources in key areas such as:

a. Support to SAGE modelling to provide strong baseline modelling of the pandemic; PPE supply and demand modelling;
b. A new MedTech analytical team focused on analysis of the market and our ICU consumables and equipment stockpiles; and
c. Expanded resource in UKHSA including bespoke resource modelling and planning the size of any safety stockpile required for future pandemics.

127. In delivering this recommendation, the Department performed deep dives into PPE and vaccine procurement during the pandemic, which included identifying where manufacturers relocated functions to the UK.

128. The aim of these deep dives was to integrate lessons learned into future opportunities to build more resilient supply chains, both specifically into these product areas, but also more widely within procurement systems. For example, SCCL has integrated the lessons learned from the PPE deep dive into their BAU practices (both in PPE and more widely) as communicated to the Public Accounts Committee on 16 March 2023.

129. SCCL are taking the following strategic approaches to build a supply chain which is resilient to supply disruption and demand surges: centralising supply whilst allowing individual procurement flexibility; improved use of data; better demand forecasting and signals; closer interactions between international and domestic suppliers; leveraging the purchasing power of the NHS; enhanced logistics; and using information about past events to inform the future make-up of emergency stock.

Technical Specifications and Commercial Guidance

130. The Inquiry has heard that the technical specifications for PPE are full of complexities and that there are significant variables. The Inquiry has also heard that clinicians have strong preferences over what they use. Such complexities and variables made the procurement of PPE during the pandemic particularly complex. In evidence provided it was heard that the procurement process was further compounded by a lack of quality guidance on procurement in a pandemic.

131. As part of a wider Departmental review of corporate services, a Commercial Reset was undertaken. The reset was in response to the significant changes to the Departments commercial activity and contract portfolio over the previous few years[31] . The Department took steps to improve governance and support to policy teams when spending public money, especially in an emergency situation. The benefits of the reset included:

a. Clearer lines of responsibility and accountability for the Department's Commercial function and key partners;
b. Strengthened commercial governance and clear escalation processes;
c. A reset of pandemic behaviours with greater discipline and control; and
d. Increased commercial awareness across the Health System.

132. In addition, in May 2021 the government published the 'Sourcing Playbook', providing further enhanced guidance covering risk allocation, pricing approaches, and assessing and monitoring the financial standing of suppliers to enable better understanding of cost-drivers and profit margins.

133. Responding to Boardman recommendation 17, Commercial accreditation and training has been extended to the health sector including Arm's Length Bodies (ALBs) and the broader NHS via Integrated Care Service (ICS) procurement leads.

Data

134. As mentioned above, due to the heavily fragmented nature of the supply chain, there was no data available on the use of PPE, or frontline inventories of PPE, during the early months of the pandemic. As the Inquiry has heard from several witnesses, this made deciding what and how much to buy a difficult task and estimates for use and for volumes required were therefore based on modelling.

135. In preparation for the handover of operational control of PPE to SCCL in March 2022 (and as recommended in response to 'The Supply of PPE During the COVID-19 Pandemic' report, dated 25 November 2020 and 'Investigation into the Management of PPE Contracts' report, dated 30 March 2022), the Department and SCCL established management information data sources to monitor and manage stock held by the programme at national level. Separate contractual data has been used to manage financial

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receipting and to pursue contractual matters. Following the data improvement work, the Department was well placed to hand over to SCCL a single, coherent, and joined up view of stock held. SCCL have put in place plans to manage disposal or ongoing distribution and sale of those products.

The National Equipment Tracking and Information System (NETIS)

136. The pandemic highlighted the lack of a national view or visibility of the medical equipment held in NHS Trusts. The NETIS system has been developed by NHS Supply Chain (NHSSC) in collaboration with the Department to provide this capability. NETIS tracks the age, location and detailed product information for NHS equipment assets held in Trusts, to provide a national level view of assets and risks. NETIS will consolidate multiple data sets to provide a single, coherent, comprehensive view of medical assets across the NHS landscape.

137. NETIS will help deliver enhanced resilience for the use and deployment of medical devices through granular, near-live data that represents a single point of truth. The enhanced visibility provided by NETIS will support strengthened supply resilience by enabling faster response in the event of supply incidents – for example, supporting equipment recall and co-ordinating mutual aid between NHS Trusts (i.e. rapidly moving equipment to where it is most needed) – and supporting improved management and efficiency of medical devices (informing procurement decisions by identifying gaps in assets held and opportunities to fill them through purchasing additional equipment).

Procurement

138. Witnesses have reflected that the normal procurement systems for PPE in the UK were not capable of quickly securing vast amounts of PPE as was needed in the pandemic. This point was illustrated in Lord James Bethell's Second Witness Statement to the Inquiry, dated 20 December 2024:

"With regard to PPE, I was frustrated that there was a global breakdown in the supply chains and production capacity for PPE, and I was hugely frustrated that our normal procurement system did not seem capable of securing the vast volumes that we needed so quickly. Matters were made worse by the slow development in understanding that COVID-19 could be transmitted by a person showing no symptoms at all (asymptomatic) or with very limited symptoms (pauci-symptomatic). This made worse the unexpected nature of the demand for PPE. And we should also remember that at the beginning of the

pandemic our knowledge of how this new virus transmitted was very poor. It would be a mistake to under-estimate the pressures on the system to find vast quantities of PPE, at an urgent rate and in competition with the major economies of the world.

Having had time to reflect on the question of the system of procurement in our healthcare system, it is clear to me that it had become increasingly optimised for cost and waste-minimisation but not built for flexibility and for resilience. I believe that was a serious mistake. Britain was not the only country to make this mistake. Given the way that the procurement system let us down, I believe we did as well as could be expected to procure the stock that we so desperately needed".

139. The Department agrees with the recommendation that the ability to scale up UK industry at pace is crucial, and indeed investing in UK manufacturers was of huge benefit during the pandemic.