UK Covid-19 Inquiry

Module 5:

Procurement

A report by The Rt Hon the Baroness Hallett DBE
Chair of the UK Covid-19 Inquiry

July 2026

HC 135

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Presented to Parliament pursuant to section 26
of the Inquiries Act 2005

Ordered by the House of Commons to be printed
14 July 2026

HC 135

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Any enquiries regarding this publication should be sent to contact@covid19.public-inquiry.uk

ISBN 978-1-5286-6581-0
E03444965 07/26 Version 1

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

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Introduction by The Rt Hon the Baroness Hallett DBE

The lack of effective pandemic preparation noted in other modules meant that the UK entered the Covid-19 pandemic with its stockpile of personal protective equipment (PPE) in a perilous condition, with shortages of vital stock and large quantities of expired stock left unattended. There were also no proper plans for the procurement and distribution of key healthcare equipment in any emergency. This left health and social care workers without adequate PPE to protect themselves, and those for whom they cared, from infection.

In the face of a lack of planning and preparedness and an inadequate stockpile, ministers and officials were forced to improvise for the Covid-19 pandemic. Across the UK they put together emergency procurement and distribution systems, often relying on the crisis response expertise of the Army, and on the private sector, to organise their operations.

Although the lack of planning caused an unnecessary delay in procuring the PPE and other equipment that healthcare workers and others desperately needed, it was a positive feature of the subsequent procurement response that key healthcare equipment was obtained at the speed and scale the crisis demanded. However, it took time and came at huge cost both in financial terms and in terms of the officials working in the system. They worked under extreme pressure to source the vital PPE and medical equipment that medical staff, care workers and others desperately needed, and the testing equipment required to stop Covid-19 spreading.

The procurement and distribution of PPE was a phenomenally complicated logistical operation, involving the coordination of supplies from the UK and around the world to more than 58,000 locations across the health and social care sectors. Identifying and buying the equipment were extremely difficult. Those involved in the emergency procurement of healthcare equipment were confronted with unenviable choices. The global market became a sellers' market with prices rising daily, if not hourly, as governments across the world fought to obtain supplies to protect their own citizens. Officials could either buy healthcare equipment at the speed and scale the circumstances demanded or lose out to others in the global market competing for the same equipment.

They were also faced with a flood of offers of supply that had to be triaged to identify the credible offers. They faced pressure from ministers and others to prioritise some offers based on their source. This led to the controversial High Priority Lane (also known until April 2020 as the VIP Lane). The source of an offer is undoubtedly relevant to the credibility of an offer – for example, an offer from a well-established manufacturer of quality goods is far more worthy of consideration than the well-intentioned but impractical offer from someone prepared to hand-knit PPE. However, all offers should be considered on the same objective criteria and connections to government should not lead to favourable treatment. Although I have identified no evidence of corruption on the part of ministers or officials, there is evidence of favourable treatment to some suppliers. The High Priority Lane has understandably, and in my view rightly, been the subject of significant public concern.

The allegations of 'cronyism', complaints about the quality of some of the PPE obtained and criticism of the surplus PPE acquired have together significantly undermined the reputation of the government procurement system. This is unfortunate given the industry, dedication

and good intent of many officials. Had the UK been better prepared for a pandemic and had officials been better equipped with appropriate information to respond, procurement decisions would have been a great deal easier, money would have been saved and equipment would have reached those who needed it at an earlier stage of the Covid-19 pandemic.

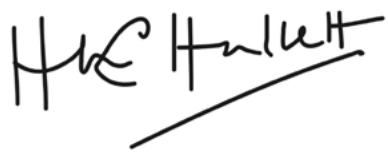
I have made 11 recommendations in this Report, focused on ensuring that, next time, the UK is better prepared for the emergency procurement and distribution of healthcare equipment. They range from improving the skill base of officials to recognising the importance of businesses, including advisers and manufacturers, in helping the government through emergencies.

Underpinning these recommendations are two key lessons from the pandemic.

The UK must diversify its international supplier base and increase its own domestic industrial resilience. The UK's strengths in life sciences and advanced manufacturing should be recognised and supported. They will be vital in the response to a future pandemic.

Ministers and officials need to be in the best possible position to make decisions on how to spend public resources in the pressure of an emergency. It is a stark fact that the UK government and devolved administrations purchased approximately £14.9 billion of PPE and yet almost £10 billion of this was wasted. This level of waste will only be avoided if, in future, investment in high-quality information systems and modern technology are placed at the heart of emergency procurement and distribution. They are key to ensuring that the UK is better prepared for the next pandemic and that public resources are spent wisely.

During Module 5, the Inquiry considered over 250 witness statements and approximately 59,000 documents as well as receiving two expert reports. During its public hearing in March 2025, 48 witnesses provided evidence including procurement specialists and supply chain officials as well as government ministers and officials. I thank them for their assistance and also thank those who contributed to the impact film played at the outset of the public hearing, together with the 24 Core Participants and their representatives, and the Inquiry's secretariat and legal team.



The Rt Hon the Baroness Hallett DBE

14 July 2026

Voices

> "*There were points during the early phases of the pandemic when CCG* [clinical commissioning group] *staff would be placing orders for gowns on Amazon. Senior staff would do this on their own credit cards and then claim back the money from the NHS Covid fund. These online orders were hugely expensive, however we were scrambling to plug the gap that* [the] *NHS Supply Chain and national pandemic stocks could not fill.*"[1]
>
> **Amanda Sullivan, Chief Executive of NHS Nottingham and Nottinghamshire Integrated Care Board**

> "*We have bare arms & faces. We are on the front line with these patients. I've had to wear my own protective goggles from home, a shower cap & colleagues have made makeshift protection wear out of bin bags in order to treat COVID-19 patients, we feel we don't have confidence in the issued PPE on the ward. And feel we are at risk of being infected & passing this virus to our families at home.*"[2]
>
> **Member of the Royal College of Nursing**

> "*Due to the lack of ventilators, at some points during the pandemic, consideration was even given to the need to train medical staff to deliver manual ventilation. This would have involved providing breathing support to a patient using a self-inflating manual resuscitator bag or mouth-to-tracheal tube ventilation.*
>
> *Although the plastic ventilators or manual ventilation was not needed, the fear of it was present during the pandemic. This placed a huge amount of stress on the staff trying to procure the equipment, and the staff delivering the direct care to extremely unwell patients.*"[3]
>
> **Simon Clarke, Managing Director of Procurement for the Birmingham and Solihull Integrated Care System**

1 INQ000520830_0035 para 153
2 INQ000553817_0017 para 50b
3 INQ000513253_0012-0013 paras 50-51

> *"I was getting Covid alerts on my phone almost every day for contact, but due to the lack of planning there was just no tests available, meaning I had to choose between earning money which I desperately needed, or potentially spreading this deadly disease. That's not something someone earning little more than minimum wage should have on their shoulders."*[4]
>
> **Carer, Every Story Matters**

> *"There was clearly anxiety amongst staff that PPE was in short supply and that critical shortages might occur, leading to exchanges about how we would manage this scenario. From an ethical point of view, we would never have asked staff to put themselves at risk, but it was always my belief that faced with this scenario, many staff would have prioritised patient care over their own safety."*[5]
>
> **Professor Colin McKay, Chief of Medicine at the Glasgow Royal Infirmary from June 2019 to March 2023**

> *"Early on, scrubs were not provided by the local health board, and ours were made by patients. We are a community practice covering approximately 14,000 residents across three villages, and the community came together making scrubs for us and homemade visors for eye protection. Although some eye protection was available through the Health Board, the patient made eye protection (worn in conjunction with a mask) was simple, cheap and did not interfere with our clinical activities."*[6]
>
> **Dr David Bailey, member of the British Medical Association and GP Partner, Wales**

> *"The mask* [sic] *we were being given were of very poor quality, straps breaking, leaving us very vulnerable as they didn't give us a tight fit around our face. The number of staff who suffered real anxiety re their own safety was huge."*[7]
>
> **Anonymised healthcare worker, response to 10,000 Voices survey carried out in 2020 by the Public Health Agency and Health and Social Care Board in Northern Ireland**

4 *Every Story Matters: Test, Trace and Isolate*, p58 (INQ000475132)
5 INQ000478114_0035 para 126
6 INQ000421938_0005 para 15
7 INQ000325799_0030

Executive summary

The emergence of the Covid-19 pandemic resulted in a global race to purchase vital supplies as governments around the world sought to protect their populations.

Vital healthcare equipment – including the PPE, testing equipment and ventilators examined in this Report – became a valuable commodity. International demand skyrocketed, global supply chains came under strain and prices rose uncontrollably. The stockpile of PPE and other equipment for the UK was inadequate to meet demand, and contracts held by the UK government to replenish stock failed, leaving the hospitals, care homes and GP surgeries that principally made up the health and social care sectors vulnerable to shortages.

The UK government and devolved administrations were wholly unprepared to increase rapidly the scale and speed of their emergency procurement and distribution operations. As a result of this failure of planning, they had to improvise and establish new – and, until then, untested – emergency procurement and distribution systems. When confronted with the fundamental problems of which and how much equipment to buy, at what prices, and how it should be distributed, ministers and officials were not equipped with either the plans or infrastructure to enable them to respond with sufficient speed and efficiency. There were clearly risks of waste caused by overbuying and large sums of public money being lost, and of buying substandard equipment that put health and social care workers at risk.

On the positive side, the UK's embassies and trade missions around the world used their contacts and expertise to identify suppliers, and domestic manufacturers rallied to answer the calls to arms. Members of the public and businesses were invited to help in the efforts to source, manufacture and supply critical equipment, including PPE, ventilators and testing equipment. The response was enthusiastic.

Unfortunately, the procurement system was not designed to cope with the number of offers. Officials were swamped and struggled to triage them effectively. They were also subject to pressure to give priority to particular offers. This led to the establishment of the High Priority Lane (also known as the VIP Lane) – a misguided attempt to give priority to the most credible offers. The existence of the High Priority Lane has led to allegations of cronyism and corruption. Although the Inquiry has not identified any cronyism or corruption on the part of government ministers or officials in the final decisions to award contracts, it has identified examples of favourable treatment given to offers put into the High Priority Lane.

This has undermined both the enormous efforts made by procurement officials to get PPE and vital medical equipment to where they were needed and trust in government procurement. Had there been more properly trained procurement staff and better technology, this could have been avoided.

As equipment was being procured and distributed, health and social care workers reported shortages and concerns about the quality and safety of the equipment that was being supplied. Issues as to the quality and safety were examined in detail in the Inquiry's Module 3 Report on healthcare systems and are being further considered in Module 6: Care sector. They are also relevant to this Report.

In May 2026, the Treasury estimated that UK government spending resulting from Covid-19 on all measures, including financial support for businesses, would total £385 billion. (To put that figure in context, total UK government spending was approximately £853 billion in 2018/19.) The total expenditure by the UK government and devolved administrations on PPE, ventilators and testing equipment between 1 January 2020 and 28 June 2022 was approximately £42.3 billion. This included:

- PPE: approximately £14.9 billion;
- NHS Test and Trace (established to lead the UK's population-wide Covid-19 testing programme): in excess of £25 billion; and
- ventilators: approximately £700 million.

This is a very significant amount of public money, albeit for the purchase of vitally important, life-saving equipment during an emergency. There was, however, significant waste. For example, of the approximately £14.9 billion spent on PPE by the UK government and devolved administrations, nearly two-thirds – almost £10 billion – was wasted.

Government spending should always represent the best possible value for money for the public and abide by standards of propriety, fairness and transparency. Trust in the integrity of high-value public procurement decisions, even when made under the intense pressure of a crisis, is critical to maintaining public confidence in the ability of governments to respond to emergencies.

Priority was given to the rapid procurement and distribution of healthcare equipment over being transparent with the public about the underlying procurement decisions. While it was important to secure vital healthcare equipment, especially in the extremely competitive global market of the pandemic, and this focus was understandable in the early stages of the pandemic, this lack of openness continued. It meant that public trust in the emergency procurement system was diminished when criticisms surfaced (for example, about the High Priority Lane).

Had the UK government and devolved administrations been better prepared for the emergency procurement and distribution response, there would have been less waste, more trust and greater confidence in the system.

The Inquiry found several major flaws in the systems responsible for emergency procurement and distribution of key healthcare equipment and supplies:

- The pandemic stockpile of PPE was not subject to an adequate system of management and oversight. It failed to take sufficient account of the range of pandemic risks or the diverse composition of the health and social care workforce.
- The bodies responsible for emergency procurement and distribution across the UK were not ready for a pandemic. There were inadequate plans to increase the speed and scale of their responses. The plans that did exist had not been stress-tested in pandemic response exercises.
- The structures established by the UK government to respond to the Covid-19 pandemic did not sufficiently integrate procurement and distribution. Vital inventory, usage rates, procurement and distribution data were not easily available to procurement teams. Procurement systems were unduly complex, inefficient and unable to cope with the large quantities of information they had to process.
- Healthcare equipment – such as PPE, ventilators and testing equipment – is subject to a complex system of regulation, which is poorly suited to an emergency. There was no 'buyer's guide' that gave adequate advice to those involved in making purchase decisions.
- There was no strategy for increasing international trade and domestic manufacturing resilience for a pandemic. The UK's supplier base was too concentrated in a single country, China, and the capabilities of domestic manufacturers had not been adequately considered in planning.
- There was not a sufficient number of officials within the UK government and devolved administrations with the skills, expertise and experience specifically in the emergency procurement of healthcare equipment.
- There was inadequate planning for the use of external advisers and businesses in an emergency procurement and distribution response.
- Public confidence in the emergency procurement system was undermined by the lack of transparency, the lack of adequate processes to control spending and the unfairness of the High Priority Lane which tended to favour suppliers with a connection to the UK government.
- The technology and data systems for emergency procurement and distribution were outdated. Systems across the UK did not allow for the adequate sharing and analysis of procurement and distribution data and did not work with each other.

Where the UK government and devolved administrations were most successful in their procurement efforts was in appealing to and harnessing the innovation, expertise and willingness of their domestic life sciences and manufacturing sectors. This was evident in the production of PPE, ventilators and testing equipment. The effective collaboration between the public and private sectors should serve as an example of how governments should respond to future pandemics.

This Report makes 11 recommendations. In summary, as well as important recommendations spanning improvements to the composition and management of the pandemic stockpile, a programme of training for officials and better transparency, governance and accountability, the Inquiry recommends:

- **establishing systems for the emergency procurement and distribution of healthcare equipment**, with a radical overhaul of supply chain resilience and emergency procurement and distribution systems;
- **creating an emergency international trade and domestic industrial strategy as part of pandemic planning**, in which key healthcare equipment is regarded as a strategic national asset worthy of investment;
- **setting specific objectives for international trade and domestic industry during a pandemic**, creating an environment to encourage investment, research and development in the advanced manufacturing of healthcare equipment to increase self-sufficiency; and
- **deploying technology and the effective use of real-time data**, which must be interoperable across the UK government and devolved administrations.

A full list of the Inquiry's recommendations is included in Appendix 3.

The UK government has started to make progress, especially with the publication of the *Pandemic Preparedness Strategy* in March 2026. However, there is more to be done.

The aims of the emergency procurement and distribution system must be, so far as is possible, to ensure that vital PPE and healthcare equipment are purchased and delivered quickly to those who need them, and to limit waste, ensuring value for money for the public. With the vast sums of money almost certainly at stake in a future pandemic, public confidence will only be retained if the UK government and devolved administrations can show that they are spending resources properly and effectively.

Chapter 1: The UK's readiness for emergency procurement and distribution

Introduction

1.1. The provision of personal protective equipment (PPE) and other healthcare supplies in a pandemic relies on a well-stocked and accessible stockpile, supplemented by an effective emergency procurement and distribution system. If PPE and other healthcare supplies do not get to those who need them quickly in the health and social care sectors – principally in hospitals and care homes – then lives are put at risk.

1.2. Public procurement is the process by which governments and public bodies buy goods and services. The principal aims of the rules that govern it are to ensure value for money, fair competition and integrity.[1] Procuring and getting key equipment to critical sectors urgently while spending public money wisely requires rigorous planning, careful preparation and stress-testing.

1.3. This chapter examines the composition, management and oversight of the stockpile held for use in a pandemic, as well as the readiness of the UK government and devolved administrations for procurement and distribution in an emergency. It also considers whether pandemic response exercises were used properly to stress-test the readiness of the UK government and devolved administrations for the emergency procurement and distribution of key healthcare equipment.

Emergency provision of personal protective equipment

The UK's pandemic stockpile

1.4. The pandemic stockpile was established by the UK government following the 2009 to 2010 H1N1 influenza pandemic ('swine flu').[2] It comprised critical healthcare equipment, including PPE such as masks, gowns and gloves, which were allocated to and stored by each of the four nations of the UK according to population size.[3] As part of preparations for the departure of the UK from the European Union (EU), a further EU exit stockpile was established to increase the resilience of the UK.[4] In February 2020, the pandemic and EU exit stockpiles were amalgamated and made available to the UK-wide pandemic response.[5]

1 INQ000539153_0013-0015 paras 29-36; INQ000528391_0010 para 33
2 *UK Influenza Pandemic Preparedness Strategy 2011,* Department of Health, 10 November 2011 (https://assets.publishing.service.gov.uk/media/5a7c4767e5274a2041cf2ee3/dh_131040.pdf; INQ000022708)
3 INQ000506956_0038-0039 paras 155-162; INQ000474864_0073 paras 308-310; INQ000521969_0008, 0013 paras 23.4, 43-44; INQ000514103_0009-0010 paras 19-21
4 INQ000492085_0054-0055 paras 18.1-18.4; INQ000528391_0010 para 35
5 INQ000528391_0056-0058, 0071 paras 208-216, 262, Table 3

Composition

1.5. Two expert committees – the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and the Clinical Countermeasures Board (a body chaired by Public Health England which provided oversight of procurement) – advised the UK government on the composition of the stockpile.[6] In formulating its advice, NERVTAG took into account the National Risk Register, one of the key tools for assessing the most serious civil contingency risks facing the UK. From 2005 until the outbreak of the coronavirus (Covid-19) pandemic, this consistently stated that pandemic influenza was the most significant civil emergency risk facing the UK.[7]

1.6. The Department of Health and Social Care followed this advice and decided that the stockpile should:

- last for 15 weeks (which was the expected duration of a single wave of an influenza pandemic);[8]
- be for use only with symptomatic patients; and
- be deployed only in hospitals.[9]

1.7. As set out in the Inquiry's Module 1 Report, the decision to place undue focus on a particular type and scale of influenza pandemic was wrong.[10] The effect on the pandemic stockpile was that it was insufficient to meet the demands of the pandemic that struck, both in quantity and in suitability.[11]

Quantity

1.8. The amount of equipment required depended on the duration of the pandemic and the extent of need.

1.9. The first wave of the Covid-19 pandemic lasted for approximately the first six months of 2020.[12] On its own, the pandemic stockpile was not sufficient to respond to a first wave of this length. Stockpile planning did not take adequate account of the potential failure of emergency contracts to supply PPE (see below) or the time it

6 INQ000571763_0016-0017 paras 61, 64; INQ000492085_0047 paras 17.7-17.8
7 INQ000145912_0012-0030, 0072-0073 paras 6.15-6.18, 6.22-6.24, 6.28, 6.33-6.36, 6.40-6.41, 6.43, 6.45-6.46, 6.50-6.52, 6.55-6.58, 6.62-6.63, 6.66-6.68, 6.71-6.72, 6.74-6.75, 6.82-6.86, 9.5-9.6, 9.9; *National Risk Register: 2020 Edition*, HM Government, 18 December 2020, pp46-52 (https://assets.publishing.service.gov.uk/media/6001b2688fa8f55f6978561a/6.6920_CO_CCS_s_National_Risk_Register_2020_11-1-21-FINAL.pdf; INQ000055874); INQ000181825_0003 para 12. See also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 3 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
8 INQ000145733_0012-0013 para 3.7
9 INQ000571763_0017, 0035 paras 64b, 127
10 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 4 (https://covid19.public-inquiry.uk/documents/module-1-full-report). See also INQ000145733_0012-0013, 0017-0018 paras 3.7, 3.23; INQ000087205_0001 para 3
11 INQ000496875_0001 para 8
12 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol II, Chapter 15 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

would take for the UK manufacturing sector to supplement the supply of PPE (see Chapter 4: Global supply chains and domestic industrial resilience).

1.10. Covid-19 infections spread symptomatically and asymptomatically.[13] As examined in the Inquiry's combined Report relating to Modules 2, 2A, 2B and 2C, asymptomatic transmission was suspected in January 2020 and confirmed in April 2020.[14] The inability to identify who may be spreading the virus meant that those particularly vulnerable to infection required greater protection and therefore more PPE. Before the emergence of the Covid-19 pandemic, there was a history of major epidemics and pandemics with widespread asymptomatic spread, but these had not been adequately taken into account in pandemic planning.[15]

1.11. The spread of Covid-19 had a devastating impact beyond hospitals.[16] PPE was needed in a wide range of settings, especially in the social care sector, but the stockpile was not established for this purpose.[17] During a pandemic, the social care sector and community healthcare providers, such as GPs and pharmacists, were expected by the Department of Health and Social Care to procure their own PPE.[18] Given the size of the social care sector and the vulnerability of those in care requiring protection from the spread of disease, this was a major failure in planning.

1.12. The Department of Health and Social Care and the groups advising it on the contents of the pandemic stockpile (NERVTAG and the Clinical Countermeasures Board chaired by Public Health England) should have taken into account a wider range of potential pandemic scenarios than a single type and scale of influenza.

Suitably fitting personal protective equipment

1.13. The diverse composition of the UK's health and social care workforce means that a number of different PPE sizes and shapes are required to reflect a range of physical characteristics.[19] To be effective, PPE must properly fit the eventual wearer. 'Fit-testing' of face masks, for example, ensures that they provide a sufficient seal around the nose and mouth of the wearer to ensure that the equipment provides protection.[20] If it does not, health and social care workers – principally doctors, nurses and care assistants – are exposed to infection and their safety is put at risk.

13 See *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol I, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
14 See *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025, Vol I, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-2-full-report)
15 See *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapters 1, 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
16 See *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
17 INQ000514103_0008 para 15; *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021, p14 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876); INQ000571763_0035 para 127
18 INQ000535015_0011 para 35; INQ000521969_0013, 0024 paras 41-42, 85; INQ000514103_0008-0009 para 17; INQ000536418_0003 para 9; INQ000521963_0003 paras 10-12; INQ000536485_0017 paras 46-47
19 INQ000528391_0188 para 712; see also *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 2 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
20 INQ000347822_0066 para 302

1.14. In September 2016, NERVTAG recommended to the Department of Health and Social Care that there should be a rolling programme of fit-testing in NHS trusts in advance of a pandemic, as it would be difficult to conduct when a pandemic emerged.[21] However, the Department of Health and Social Care and Public Health England (which carried out procurement at the department's instruction, acting on the advice of the Clinical Countermeasures Board and NERVTAG) had not adequately taken into account the physical characteristics of the health and social care workforce when procuring some stockpile items.[22] This resulted, for example, in an insufficient size and fit range of filtering facepiece respirator class 3 (FFP3) masks.[23]

1.15. When the issue of poorly fitting PPE was brought to the attention of the Department of Health and Social Care and NHS England by the British Medical Association and the Royal College of Nursing, from April 2020 to at least January 2021, the department and NHS England increased their efforts to fit-test staff and procured a wider range of masks for different face shapes – increasing the types and brands of masks available from 4 to 12.[24] As considered in detail in the Inquiry's Module 3 Report, the Department of Health and Social Care increased fit-testing capacity during the pandemic.[25] However, this was done amid the crisis, when PPE was already in short supply, staff confidence in the PPE supply was already low and the procurement system was under pressure.[26]

1.16. As the Inquiry noted in its Module 3 Report, the pandemic stockpile of PPE should better reflect the requirements of the health and social care workforce. Their safety is crucial. Decisions about which PPE is procured and stockpiled should be informed by regular fit-testing.[27]

Oversight and management of the stockpile

1.17. Effective oversight and active management of the stockpile are essential to ensuring that it is kept fully replenished. This involves the procurement of new equipment, product cycling (ie using stockpiled PPE in healthcare systems prior to its expiry) and shelf-life extension (by testing and revalidating stock).[28]

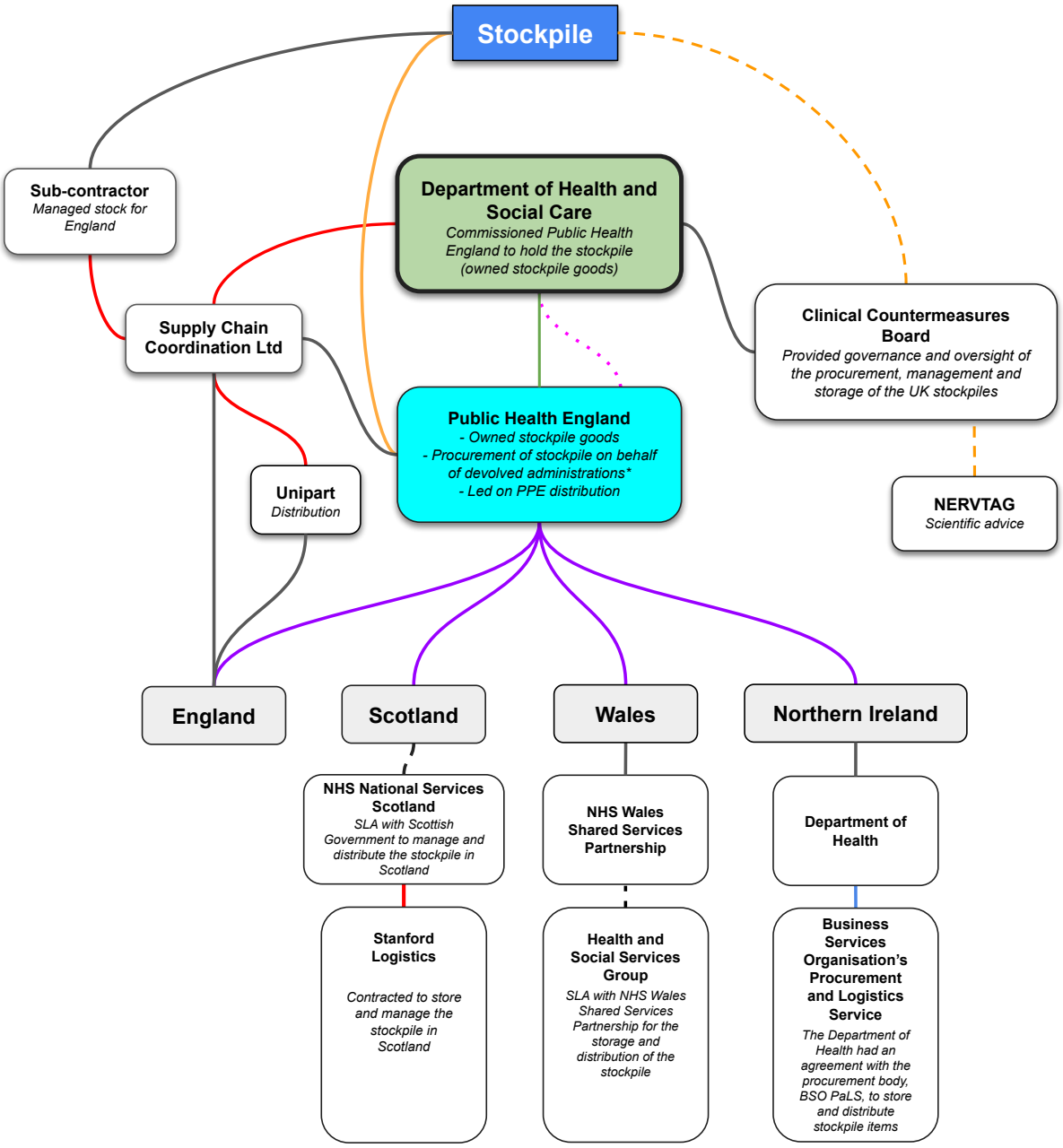
21 INQ000130548
22 INQ000528391_0189 paras 718-720; Clara Swinson 19 June 2023 189/16-21; Christopher Wormald 12 November 2024 40/24-41/24; Matt Hancock 21 November 2024 195/5-8, 196/5-9
23 INQ000573995_0028 para 88e; INQ000521972_0011 paras 3.8-3.9; INQ000148429_0115-0117 paras 464-465, 473-475
24 INQ000528391_0007 para 22; INQ000522172; INQ000097874
25 INQ000528391_0007 para 22
26 Jonathan Marron 5 March 2025 210/18-212/8
27 *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
28 INQ000492085_0051 para 17.31

Responsibility for the stockpile

1.18. Responsibilities were allocated to an array of different bodies or sub-contracted to companies that were remote from the ultimate decision-makers – Public Health England, the Clinical Countermeasures Board, the devolved administrations and the Department of Health and Social Care.[29] A number of bodies across the UK were responsible for the oversight and management of the stockpile (see Figure 1).

29 INQ000521972_0002-0004, 0011 paras 1.4, 2.1-2.3, 3.8; INQ000492085_0016, 0046 paras 5.18, 17.2-17.5; INQ000536418_0010-0011 paras 40-41; INQ000528391_00003, 0010, 0045 paras 7, 33, 160; INQ000506956_0040-0041 paras 164-165, 167; INQ000131513; INQ000521969_0013, 0016 paras 43, 54; INQ000536419_0007 paras 26-28; INQ000536425_0012 para 51

Figure 1: The bodies responsible for management of the pandemic stockpile



*through a Memorandum of Understanding between the Secretary of State for Health and Social Care and ministerial counterparts in Scotland, Wales and Northern Ireland.

- Management and logistics
- Commissioning relationship
- Procurement relationship
- Governance and oversight of procurement, management and storage of stockpile goods
- Sought assurance in storage and distribution arrangements
- Contractual relationship
- Service Level Agreement (SLA)
- Agreement

Source: INQ000521972_0011 para 3.8; INQ000536418_0010 para 40; INQ000528391_0003, 0010, 0045, 0051-0053 paras 7, 33, 160, 192, 196; INQ000492085_0046-0048 paras 17.2-17.8, 17.14-17.16; INQ000506956_0041 para 167; INQ000521969_0013, 0016 paras 43, 54; INQ000536419_0007 paras 26-28

1.19. The key bodies were:

- the Department of Health and Social Care, which, as the lead UK government department for pandemic preparedness, commissioned Public Health England to take responsibility for the PPE part of the stockpile, including procurement on behalf of all four nations;
- the Clinical Countermeasures Board (comprising members from across the UK), which liaised with NERVTAG on the composition of the stockpile and had regular oversight of stockpile levels;[30] and
- Public Health England, which chaired the Clinical Countermeasures Board.

Public Health England made the final decisions on procurement, cost, volume and product specification and allocated stock between the four nations pursuant to a Memorandum of Understanding.[31]

1.20. The UK government and devolved administrations appointed their respective central procurement bodies to arrange for the storage and inventory management of the stock:

- In England, this was Supply Chain Coordination Ltd (a company wholly owned by the Department of Health and Social Care until 1 October 2021, when it was transferred to NHS England).[32]
- In Scotland, this was NHS National Services Scotland.[33]
- In Wales, this was NHS Wales Shared Services Partnership (accountable to NHS trusts and health boards in Wales).[34]
- In Northern Ireland, this was the Business Services Organisation's Procurement and Logistics Service.[35]

1.21. The central procurement bodies across the UK provided information about their share of the stockpile to the Clinical Countermeasures Board for discussion and planning purposes.[36] In England and Scotland, the central procurement bodies sub-contracted their stockpile management responsibilities to private companies.[37] In Scotland, the role of NHS National Services Scotland was to store and distribute stock as directed by the Scottish Government. It provided information to the Scottish Government on stock status, including expiry data, to inform policy and operational decisions taken at government level. Decisions about how expired stock should be

30 INQ000528391_0010, 0045 paras 33, 160; INQ000131513
31 INQ000492085_0046 para 17.4; INQ000521972_0011 para 3.8; INQ000536418_0010 para 40
32 INQ000492085_0046 paras 17.8-17.9
33 INQ000521969_0013, 0015 paras 43, 47
34 INQ000536425_0013 para 55; INQ000527571_0019 para 63
35 INQ000514103_0009 paras 18-19
36 INQ000023080_0004-0008
37 INQ000521969_0016 paras 53-54; INQ000492085_0046 paras 17.1-17.4

managed, including write-off, replenishment and revalidation, were taken by the Scottish Government and the Department of Health and Social Care.[38]

1.22. According to Professor Albert Sanchez-Graells (expert witness on public procurement during emergencies), the control and management of the pandemic stockpile involved a "*complex chain of contracts or equivalent relationships*" that caused difficulties, including in the procurement of goods to replenish the stockpile.[39] Although decisions on procurement, cost, volume and product specification were ultimately taken by Public Health England when PPE needed to be replenished, the structure was overly diffuse and contained too many layers. The Department of Health and Social Care failed to ensure that there was an efficient and effective structure which provided oversight and active management of the stockpile.

Replenishing the stockpile

1.23. Keeping the stockpile replenished requires procurement decisions to be made efficiently and expired stock to be systematically identified and replaced.

1.24. Decision-making relating to new procurements for the stockpile was slow. Before the pandemic, it typically took 12 months to procure items for the stockpile.[40] The Inquiry was told that such periods were commonplace in public procurement.[41] For example, in June 2019, NERVTAG recommended to the Clinical Countermeasures Board the procurement of 20 million gowns. However, it was only in October 2019 that the recommendation was discussed by the Clinical Countermeasures Board, which then took until February 2020 to start a procurement exercise, with delivery taking place later that month.[42] Sir Christopher Wormald, Permanent Secretary to the Department of Health and Social Care from May 2016 to December 2024, told the Inquiry that this speed of decision-making was not unusual due to the need to consult widely before moving to tender, especially given the UK-wide approach to the stockpile.[43]

1.25. It resulted in there being no gowns in the stockpile until February 2020. As a result, gowns for England, Scotland and Wales had to be procured through emergency procurement procedures, at both higher risk and higher cost than would otherwise have been the case.[44] Northern Ireland was the exception in that it held a small number of gowns resulting from its decision to purchase them in the 2009 to 2010 H1N1 influenza pandemic.[45] The need for agreement by multiple bodies that did not meet frequently enough meant that decisions to add to the stockpile were taken and put into action too slowly.

38 INQ000521969_0016 para 56
39 INQ000539153_0060 para 192
40 INQ000492085_0050 para 17.27
41 INQ000528391_0056 para 207
42 INQ000571763_0018 para 68; INQ000528391_0055-0056 paras 206-207
43 Christopher Wormald 12 November 2024 15/10-16/12; INQ000571763_0018 para 68
44 *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers,* Northern Ireland Audit Office, 1 March 2022, p36, para 3.23 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882)
45 INQ000474864_0073 para 310

1.26. For the pandemic stockpile to be effective, PPE at or close to expiry needs to be systematically identified and replaced. The stockpile across all four nations of the UK contained significant quantities of expired stock. As materials degrade over time, most PPE products have a 60-month shelf life from the point of manufacture. The shelf life of some products, such as FFP3 masks, may be extended subject to rigorous testing and confirmation that they remain fit for use.[46] A process of replenishing expired stock had begun in approximately October 2019 and was accelerated in February 2020, but by March 2020 it had not been completed.[47]

1.27. For example, of the 3.8 million masks held in England in January 2020, it was anticipated that only 1.3 million or 34% would be confirmed to be in date and therefore usable after testing by April 2020.[48] In Wales, there were no in-date FFP3 masks.[49] In Scotland, there were significant quantities of expired stock across a range of PPE types, meaning that equipment was unusable.[50] Between February and March 2020, due to nearly all of their stock having expired, the devolved administrations had to rely on England to provide them with FFP3 masks, but even these were to reach the end of their shelf life by June 2020.[51] Public Health England and the Department of Health and Social Care arranged for shelf-life extension (involving testing and revalidating stock) and quality assurance testing to take place for expired stocks of FFP3 masks.[52] As a result of the high proportion of expired FFP3 masks in the stockpile, the programme of shelf-life extension had to be accelerated.[53] There was also insufficient time to explain adequately to healthcare workers what was being done – reducing their confidence in the PPE being supplied.

1.28. An assessment in October 2019 revealed that the stockpiles of aprons and gloves in England were at 21.9% and 24.4% of the target volume respectively.[54] When the Department of Health and Social Care re-examined the stockpile in February 2020 (as a result of quality assurance, shelf-life assessment and procurement), stock was found to be at only 75% of the target volume for aprons and 69% for gloves.[55] As a consequence of insufficiently proactive management of the stockpile by the Department of Health and Social Care and Public Health England, including by allowing equipment to approach or pass its expiry date, the stockpile was below its target volumes across the UK.

1.29. It was not until February 2020, when Matt Hancock MP (Secretary of State for Health and Social Care from July 2018 to June 2021) asked for updated information about the stockpile, that he was informed in detail of its condition.[56] Prior to this, he had

46 INQ000492085_0050-0051 para 17.29
47 INQ000528391_0010 para 34; INQ000023080_0005-0006; INQ000560897_0078 para 299
48 INQ000330795; see also INQ000528391_0053-0054 para 197, Table 1
49 INQ000300270
50 INQ000320477
51 INQ000528989_0001-0004; INQ000485721_0135-0136 para 344, Table 2; INQ000300270; INQ000339164_0002; INQ000298993_0003
52 INQ000560897_0078 para 299
53 INQ000528989_0005 para 48; INQ000551495_0003-0004; INQ000553817_0011-0012 paras 34-35
54 INQ000528391_0053-0054 para 197, Table 1
55 INQ000528391_0075 Table 4
56 INQ000551269_0003

been informed that the UK was world-leading in its pandemic preparations.[57] Once he had access to modelling about the likely rate at which stock would be used, he immediately asked for more stock to be procured.[58]

1.30. Even taking into account that the stockpile was not at its target volume and that the initial demand for PPE was greater than expected – because Covid-19 was classified as a high consequence infectious disease – it was used up more quickly than the UK government and devolved administrations had planned.[59] As early as March 2020, modelling suggested that the PPE stockpiled across the UK would not last long.[60] Cabinet Office analysis completed on 19 March 2020 revealed that stocks of aprons and certain types of masks in England would be used in less than two weeks.[61] In Scotland, by April 2020, the stockpile was very low: NHS National Services Scotland held less than one day's worth of long-sleeved gowns and FFP3 masks and only two days' worth of visors, with some NHS boards reporting shortages of PPE.[62] In Wales, the stocks of gloves lasted for approximately one and a half weeks, aprons six weeks and eye protectors ten weeks.[63] In Northern Ireland, by March 2020, there were only approximately three weeks' worth of gloves, one week's worth of aprons and no eye protection equipment at all.[64]

1.31. The UK government and devolved administrations should not have tolerated below-target volumes and expired equipment in the pandemic stockpile. Decisions to procure new equipment ought to have been made with greater urgency by Public Health England, the Clinical Countermeasures Board and the devolved administrations. With better management and oversight in the form of regular inspections, reporting and action to remedy any deficiencies, shelf-life extensions could have taken place on a rolling basis and new equipment could have been procured. As the Government Internal Audit Agency observed in 2020:

> "[G]*reater clarity is needed regarding accountability / roles and responsibilities (especially where there are handoffs or third-party suppliers involved) as well as intelligence sharing protocols*."[65]

57 INQ000536350_0008 para 36
58 INQ000536350_0012 para 55
59 INQ000571763_0026 para 95
60 INQ000528389_0044 para 3.39; *Covid-19: Personal Protective Equipment*, Audit Scotland, June 2021, pp4, 11, para 14 (https://audit.scot/uploads/docs/report/2021/briefing_210617_ppe.pdf; INQ000108737); INQ000474864_0078-0079 para 329, Table 1; *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers,* Northern Ireland Audit Office, 1 March 2022, p34, Figure 5 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882). Statistical models are tools for analysing complex data, identifying patterns, and informing evidence-based decision-making where direct measurement is not possible. Figures from modelling are estimates only, and different statistical models will produce different outcomes. These estimates are not based on direct observations. They are therefore limited by the underlying assumptions used in the models and are subject to uncertainty.
61 INQ000528389_0044 para 3.39
62 *Covid-19: Personal Protective Equipment*, Audit Scotland, June 2021, pp4, 11, para 14 (https://audit.scot/uploads/docs/report/2021/briefing_210617_ppe.pdf; INQ000108737)
63 INQ000474864_0078-0079 para 329, Table 1
64 *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers,* Northern Ireland Audit Office, 1 March 2022, p34, Figure 5 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882)
65 INQ000057530_0014

Accessing the stockpile

1.32. Fast and easy access to PPE held in a stockpile is crucial in responding to the early stages of a pandemic. Key equipment must reach health and social care workers without unnecessary delay. Issues with stockpile accessibility were not reported by the devolved administrations.

1.33. However, in England, the pandemic stockpile was held in a single storage warehouse in Haydock, Merseyside.[66] Emily Lawson (later Dame Emily Lawson), National Director for Transformation and Corporate Operations at NHS England (and, from April 2018, NHS Improvement) from November 2017 to April 2020, was given the task in March 2020 of investigating distribution issues. She explained that it was "*effectively a deep-freeze*".[67] For PPE to be distributed, pallets first had to be retrieved from the storage warehouse before being moved to distribution centres, where they could be broken down into separate packages for delivery to tens of thousands of health and social care settings across the UK.[68]

1.34. As a consequence of the pandemic stockpile being stored in a single location in deep storage, supplies in England were not immediately ready to be distributed when Covid-19 struck. As examined in Chapter 2: Emergency procurement and distribution during the pandemic, this was a major and complex operation. There were delays initially in getting PPE to hospitals and other settings.[69]

1.35. The poor accessibility of the pandemic stockpile was a foreseeable problem. It was not adequately addressed in pandemic planning by the Department of Health and Social Care and Public Health England. The bodies responsible for the pandemic stockpile across the UK must, in future, ensure that it is readily accessible for distribution while emergency procurement is scaled up to meet ongoing demand.[70]

Personal protective equipment procurement and distribution

1.36. The PPE procurement and distribution plans that did exist were afflicted by three key problems:

- an overreliance on 'just-in-time' contracts;
- no backup emergency procurement plans; and
- inadequate distribution plans.

66 INQ000492085_0047-0048 paras 17.10-17.13
67 Emily Lawson 11 March 2025 12/1-11
68 Paul Webster 11 March 2025 127/9-128/14
69 Emily Lawson 11 March 2025 24/4-26/25
70 INQ000492085_0049 para 17.25

Overreliance on just-in-time contracts

1.37. In the event of a pandemic, Public Health England (through Supply Chain Coordination Ltd) had contracts ready with PPE suppliers to replenish the pandemic stockpile for all four nations of the UK in an emergency.[71] These just-in-time contracts were expected to ensure that suppliers would deliver PPE to warehouses in the UK shortly before it needed to be distributed.[72]

1.38. The contracts were considered to be more cost-effective than having a larger pandemic stockpile with higher storage costs. Suppliers were checked every six months to ensure that they would be able to supply PPE in an emergency.[73] On 31 January 2020, Supply Chain Coordination Ltd activated its just-in-time contracts.

1.39. In February 2020, under the direction of the UK government, the company sought to increase its purchasing activities to respond to an anticipated acceleration in demand.[74] However, as supply chains collapsed, the contractors were unable to deliver the promised supplies. Global demand for PPE surged, creating a turbulent market with restricted exports, disrupted freight, transport bottlenecks and broken supply chains.[75]

1.40. As examined in Chapter 4: Global supply chains and domestic industrial resilience, it was clear that global supply chains for healthcare equipment were over-concentrated in a single country (China). It was also predictable that, in the event of a global pandemic, global demand and competition for this equipment would increase rapidly and there would be raw material shortages, a reduction in production and delays in international deliveries. Although just-in-time contracts are a sensible part of planning, overreliance on them was therefore misplaced. Before the Covid-19 pandemic, the Department of Health and Social Care and Public Health England should have instructed Supply Chain Coordination Ltd to have plans in case contracts failed. These should have included arrangements with a wider pool of suppliers and manufacturers in the UK and internationally to diversify the routes and means to supply healthcare equipment.[76]

No backup emergency procurement plans

1.41. Supply Chain Coordination Ltd had not been instructed by the Department of Health and Social Care to create a backup emergency PPE procurement plan in the event that the just-in-time contracts failed, and there was no such plan in place.[77]

71 INQ000528391_0054-0055 paras 200-203
72 INQ000474864_0017 paras 74-75
73 INQ000528391_0055 para 203
74 Emily Lawson 11 March 2025 18/15-22
75 INQ000474864_0086-0095 paras 357-397
76 INQ000057528_0005; INQ000492085_0029-0030 paras 9.4-9.8
77 INQ000528293_0007 para 29; INQ000492085_0056 para 19.5, table rows 1-2

1.42. Supply Chain Coordination Ltd was only just starting to consider the general risks of supply chain disruption when the Covid-19 pandemic emerged.[78] It considered that a global pandemic was a "*more far-fetched*" scenario, and the modelling on which it relied did not envisage a pandemic on the scale of Covid-19.[79] Supply chains specifically for the replenishment of the stockpile were not viewed by Supply Chain Coordination Ltd as part of its remit but as a task for the UK government.[80] Describing the situation in England, Major General Phillip Prosser (Brigadier Commander of the 101 Logistic Brigade who assisted in the Army-led intervention to deliver PPE during the pandemic) observed: "[T]*here didn't seem to be a plan.*"[81] This was a failure in pandemic planning by the Department of Health and Social Care.

1.43. In Scotland, Wales and Northern Ireland, although there had been some consideration by the central procurement bodies of disruption in the event of an exit from the EU or a pandemic, it was expected that the pandemic stockpile and normal procurement arrangements would suffice.[82] As in England, they were wrong.

Inadequate distribution plans

1.44. The logistics for the effective distribution of PPE are integral to pandemic planning. However, distribution of centrally procured PPE had not been part of pandemic planning across the UK.

1.45. In non-pandemic times, Supply Chain Coordination Ltd supplied only approximately half the PPE used by the 226 NHS trusts in England; the other half was bought by NHS trusts on the private market.[83] It did not supply to social care or community health settings, such as GP surgeries, pharmacies or dental practices, which also purchased their own PPE. It had not been instructed by the Department of Health and Social Care or Public Health England to create an emergency PPE distribution plan for a pandemic for the health and social care sectors in their entirety.[84]

1.46. In the Scottish Government, there was an assumption by its Health and Social Care Directorates that any distribution to social care settings would be made in conjunction with local authorities, but there were no detailed plans for such distribution.[85] In Wales, NHS Wales Shared Services Partnership did not generally supply social care settings and the social care sector was not included in its pandemic stockpile distribution plans.[86] In Northern Ireland, the Business Services Organisation's Procurement and Logistics Service procured PPE for care providers such as adult care homes managed directly by Health and Social Care trusts but not

78 INQ000492085_0029 para 9.5
79 INQ000492085_0029, 0059 paras 9.4, 19.9.1; see also INQ000560895_0010 para 28; Phillip Prosser 26 March 2025 163/12-21
80 INQ000492085_0029-0030 para 9.6
81 Phillip Prosser 26 March 2025 140/11-21, 146/25-147/21
82 INQ000506695; INQ000498141_0007 para 18; INQ000320497_0005; INQ000514103_0017-0018 paras 40-41
83 INQ000659765_0008 para 31
84 INQ000492085_0056 para 19.5, table rows 1-2; INQ000409265_0003-0004 paras 3.1-3.2
85 INQ000498141_0008 para 20
86 INQ000506956_0042, 0068 paras 177, 288

for the substantial number of independent providers.[87] This meant that organisations that were not included in business-as-usual supply and delivery plans during the pandemic suddenly required rapid access to PPE, posing a significant logistical challenge.

1.47. The existing plans for the logistics and distribution of PPE by the health departments of all four governments in the UK were inadequate to manage the sudden increase in demand and the coordination required to deliver it to users. It was a complex and challenging operation – once the distribution operation was established, PPE was delivered to approximately 58,000 locations across the health and social care sectors in England alone.[88] The UK government and devolved administrations all relied on the Army's logistical expertise to some extent.[89]

1.48. The plans that were in place for the sourcing and distribution of PPE in the social care sector by local authorities, the private sector and others are being considered in detail in Module 6: Care sector.

Personal protective equipment in pandemic response exercises

1.49. As noted in the Inquiry's Module 1 Report, the aim of simulation exercises is to approximate, as far as possible, the circumstances in which events such as a pandemic arise and to test the ability of institutions, structures and systems to respond to the emergency. It is by examining the detail of how to respond to a whole-system civil emergency that the system is stress-tested and gaps and flaws in planning may be discovered.[90]

1.50. The UK government and devolved administrations have accordingly carried out and participated in pandemic preparedness exercises for many years.[91] These were opportunities to stress-test, improve and prepare the whole-system response, including the emergency procurement and distribution systems for key healthcare equipment across the UK.

87 INQ000514103_0008-0009 paras 15, 17
88 *COVID-19: Our Action Plan for Adult Social Care*, Department of Health and Social Care, 15 April 2020, p6, para 1.8 (https://assets.publishing.service.gov.uk/media/5e973154d3bf7f412a086070/covid-19-adult-social-care-action-plan.pdf; INQ000299661); INQ000560895_0011 para 31
89 INQ000538646_0038 para 131; INQ000512904_0015, 0047 paras 2.34, 5.26-5.27
90 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
91 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report); INQ000528391_0049 para 183

1.51. The importance of PPE to a pandemic response arose in a number of preparedness exercises.[92] These included:

- **Exercise Shipshape (England and Wales, 2003)**: This warned that there was "*poor access*" to PPE and that PPE stocks and access to PPE needed to be "*clarified*".[93]
- **Exercise Alice (UK government, 2016)**: This highlighted the need to ensure access to PPE and suggested that stockpiles were a means of ensuring that PPE was available.[94]
- **Exercise Cygnus (UK government and devolved administrations, 2016)**: This observed that the UK government and devolved administrations should continue to work together to ensure consistency in distribution planning and that NHS England, Public Health England, the Care Quality Commission and local authorities needed to develop a whole-system approach for the distribution of PPE to "*health and care staff*".[95] It suggested that, during a pandemic, PPE should be distributed from a wider range of locations.[96]
- **Exercise Iris (Scotland, 2018)**: This noted that availability of PPE would be a key part of the early response to a pandemic.[97]

1.52. While these findings were useful, little was done to implement the recommendations based on them, which were themselves limited. None of the pandemic response exercises conducted by the UK government and devolved administrations properly stress-tested the emergency procurement and distribution of PPE. Although some of the exercises raised general and broad concerns about access to and distribution of PPE, they did not make specific recommendations on how, in an emergency, procurement and distribution systems would be established to respond at the necessary speed and scale.[98] For example, Exercise Cygnus, which took place in 2016 and was delivered by Public Health England on behalf of the Department of Health and Social Care, assessed the UK's preparedness for an influenza pandemic,

92 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 and Table 7 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
93 INQ000235217_0012-0014
94 *Report: Exercise Alice – Middle East Respiratory Syndrome Coronavirus (MERS-CoV)*, Public Health England, 15 February 2016, pp6, 9 (https://assets.documentcloud.org/documents/21080373/report-exercise-alice-middle-east-respiratory-syndrome-15-feb-2016.pdf; INQ000090431)
95 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza – 18 to 20 October 2016*, Public Health England, 13 July 2017, pp33, 35, paras e, k (https://data.parliament.uk/DepositedPapers/Files/DEP2020-0621/Exercise_Cygnus_Report.pdf; INQ000056232); *Report: Exercise Alice – Middle East Respiratory Syndrome Coronavirus (MERS-CoV)*, Public Health England, 15 February 2016, p9 (https://assets.documentcloud.org/documents/21080373/report-exercise-alice-middle-east-respiratory-syndrome-15-feb-2016.pdf; INQ000090431)
96 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza – 18 to 20 October 2016*, Public Health England, 13 July 2017, p25 (https://data.parliament.uk/DepositedPapers/Files/DEP2020-0621/Exercise_Cygnus_Report.pdf; INQ000056232)
97 *Exercise Iris: Report*, Scottish Government, 12 March 2018, pp8, 15 (https://www.gov.scot/binaries/content/documents/govscot/publications/corporate-report/2020/06/exercise-iris-report/documents/exercise-iris-report/exercise-iris-report/govscot%3Adocument/Exercise%2BIris%2B-%2BFinal%2Breport.pdf; INQ000103013)
98 *Report: Exercise Alice – Middle East Respiratory Syndrome Coronavirus (MERS-CoV)*, Public Health England, 15 February 2016, pp6, 9 (https://assets.documentcloud.org/documents/21080373/report-exercise-alice-middle-east-respiratory-syndrome-15-feb-2016.pdf; INQ000090431); *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza – 18 to 20 October 2016*, Public Health England, 13 July 2017, p25 (https://data.parliament.uk/DepositedPapers/Files/DEP2020-0621/Exercise_Cygnus_Report.pdf; INQ000056232)

but did not address the continuity of PPE supply or the resilience of supply chains.[99] The exercises did not address adequately or stress-test:

- the composition and accessibility of the pandemic stockpile;
- the use of just-in-time contracts;
- the establishment of an emergency procurement system;
- the practical implementation of distribution plans; or
- the provision of PPE, specifically to the social care sector.

1.53. These were missed opportunities. Even in the absence of specific recommendations, as examined in the Inquiry's Module 1 Report, the UK government and devolved administrations should have taken the warnings in the exercises seriously and undertaken further work to address the concerns raised.[100]

Changes to the pandemic stockpile following the Covid-19 pandemic

1.54. Each nation of the UK now has responsibility for its own pandemic stockpile.[101] For example, in England since November 2022, the pandemic stockpile has taken into account five potential routes by which an infection may spread (respiratory, contact, sexual/blood, oral and vector (such as a parasite)).[102] PPE is held in multiple, non-deep storage warehouses and is capable of being accessed and distributed at speed.[103] Supply Chain Coordination Ltd is required to provide "*full coverage across health and social care*".[104] There is also consideration of contracts requiring suppliers to hold stocks of raw materials, such as rubber and plastics, and to give priority to supplying the Department of Health and Social Care in the event of a pandemic.[105]

1.55. Although these are positive developments, the changes do not:

- sufficiently simplify the governance structures;
- ensure that the stockpiles are maintained at an adequate level; or
- adequately prepare for the next pandemic.

99 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza – 18 to 20 October 2016*, Public Health England, 13 July 2017, p36, paras 1.1-1.3 (https://data.parliament.uk/DepositedPapers/Files/DEP2020-0621/Exercise_Cygnus_Report.pdf; INQ000056232)
100 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
101 INQ000659765_0023 para 101; 'Vector-borne diseases', World Health Organization, 26 September 2024 (https://www.who.int/news-room/fact-sheets/detail/vector-borne-diseases; INQ000660147)
102 INQ000659765_0014 para 63
103 INQ000659765_0023-0024 para 103
104 INQ000624781_0003; INQ000659765_0022 para 97; INQ000492085_0056-0057
105 INQ000659765_0025 para 107

Simplification of governance structures

1.56. The new governance structures, while showing some improvement to the arrangements before the pandemic, still comprise multiple interconnected boards and groups. Each has a separate remit and composition. They include:

- the Pandemic Preparedness Portfolio Delivery Board, a group of officials from across the UK government and devolved administrations, which has overall responsibility for pandemic preparedness, including the PPE in the stockpiles;
- the Clinical Countermeasures Policy and Programme Board (chaired by the UK Health Security Agency), which reports to the Pandemic Preparedness Portfolio Delivery Board and sets the strategic direction for, assures delivery of and oversees PPE;
- the PPE Working Group within the Department of Health and Social Care, which reviews and informs policy development and implementation for PPE; and
- the Stockpile Governance Board within the Department of Health and Social Care, to improve oversight of the PPE stockpile.[106]

It is unlikely, given the complexity of this arrangement, that the speed of decision-making to keep the pandemic stockpiles replenished and up to date with evolving pandemic risks will have improved. The structure should be further simplified and streamlined (as recommended by the Inquiry in its Module 1 Report).[107]

Ensuring adequate stockpile levels

1.57. Shortages in the stockpiles at the time of the next pandemic remain an ongoing risk. With the exception of Scotland, target volumes of PPE across the UK are not being met. In December 2024, June 2025 and September 2025, the stockpiles in England, Wales and Northern Ireland were short of supplies.[108]

1.58. Although the Pandemic Preparedness Portfolio Delivery Board is responsible for overseeing and managing the stockpile and Supply Chain Coordination Ltd produces monthly reports on the stockpile's status, even when stock is within three months of expiry, there is no commitment by the Department of Health and Social Care to it being replaced.[109]

1.59. Lengthy lead times in securing new PPE continue to be accepted as the norm.[110] In December 2024, it took one year following ministerial sign-off for a product to be added to the stockpile and, in April 2025, the lag between ordering and receiving

106 INQ000659765_0014-0018 paras 64-81
107 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Recommendation 1 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
108 INQ000658595_0003; INQ000658601_0005; INQ000658604_0004
109 INQ000659765_0020-0021 paras 90, 93
110 INQ000658595_0003

gloves was also one year.[111] The Stockpile Governance Board discussed acceptable stock levels when informed that the stockpile was below target level in July 2025, and there continues to be a debate about what should be done in the event of supply chain disruption.[112] The Department of Health and Social Care told the Inquiry that work to ensure that the stockpile meets and remains at target volumes is ongoing.[113]

1.60. It is clear that not enough has yet been done. There remains a risk that the stockpiles contain expired stock which will require testing for safety in the middle of a future pandemic. The UK government and devolved administrations must ensure that their stockpiles are subject to a rigorous system of oversight and management which ensures that they are sufficient and ready to be deployed quickly to the health and social care sectors in a pandemic.

Preparing for the next pandemic

1.61. There is always the possibility of 'Disease X', a hypothetical emerging future pathogen currently not known to cause human disease, with the potential to cause a pandemic, whatever its origins.[114] It is not proportionate to stockpile for every possible pandemic risk, but, to ensure that there is an effective procurement and distribution response, systems must be properly stress-tested in pandemic response exercises for their flexibility and adaptability to the crisis.

1.62. While the stockpile in England now takes into account a wider range of potential routes of transmission, it does not yet specifically track the pandemic risks identified in the National Security Risk Assessment (the main tool for assessing the most serious civil contingency risks facing the UK). It should be aligned with and weighted to the range and severity of pandemic risks, as recommended by the Inquiry in its Module 1 Report.[115]

Emergency provision of ventilators

1.63. Patients who are struggling to breathe require respiratory support in the form of additional oxygen, which may be provided through 'invasive' (mechanical) or 'non-invasive' ventilators. Mechanical ventilators breathe for a sedated patient and are required for the most severe respiratory failure, while non-invasive ventilators provide oxygen at various pressures to a conscious patient, sometimes via a mask.[116] The use of ventilators requires a range of specialist, complex machinery as well as

111 INQ000658594_0006 para 5.2.5; INQ000658600_0003
112 INQ000658602_0005-0006; INQ000659765_0018 paras 79-81
113 INQ000659765_0025 para 106
114 INQ000196611_0007-0008 paras 8, 13; see also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
115 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Recommendation 3 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
116 INQ000518349_0006-0007 paras 21a-21b

medicines and consumable items, including supplies of oxygen, syringe drivers, tubing and filters.[117]

1.64. As noted in the Inquiry's Module 3 Report, the UK entered the pandemic with a lower critical care capacity than in comparable countries and without enough ventilators for a pandemic on the scale of Covid-19.[118] An increase in ventilator capacity was not required during the swine flu pandemic and the UK's baseline ventilator capacities were not tested further.[119] In addition, Sir Gareth Rhys Williams (UK Government Chief Commercial Officer from March 2016 to July 2024) told the Inquiry that there was not:

> "*an inventory of how many ventilators: what type, age, state of repair, and where,* [which] *made trying to estimate how many we would need even harder*".[120]

1.65. In non-pandemic times, NHS trusts in England made individual purchasing decisions about ventilators.[121] Professor Charlotte Summers and Dr Ganesh Suntharalingam, expert witnesses on intensive care, told the Inquiry in Module 3 that there was "*inadequate national and local planning*" to increase the UK's ventilation capacity.[122]

1.66. At the start of the pandemic, it was understood that Covid-19 caused the lungs to fail and ventilators were needed to take over the body's breathing process to allow patients time to fight off the infection and recover.[123] However, in the early weeks of the pandemic, there was significant uncertainty as to how many inpatient ventilator beds would be required to treat patients with Covid-19. In March 2020, the Department of Health and Social Care and NHS England estimated (based on survey information) that healthcare systems had access to 6,000 to 8,000 ventilators across the whole of the UK.[124] The modelling estimated that the number of ventilator beds required in the UK would significantly exceed supply.[125] Between 12 February and 17 March 2020, estimates varied considerably between 59,000 and 138,000 ventilator beds being needed.[126] As Sir Gareth Rhys Williams explained:

> "*We had not anticipated the need for ventilators and so started the pandemic with many fewer than I believe is the case for other countries (on a per capita basis) which … meant that we were always going to be scrambling to rectify the situation.*"[127]

117 INQ000518349_0006-0008 paras 21-23
118 Ramani Moonesinghe 17 March 2025 131/13-25; see *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
119 INQ000513708_0009 para 33
120 INQ000536362_0036-0037 para 114
121 INQ000572261_0021 para 99
122 INQ000474255_0067 para 172
123 INQ000497031_0064 para 4.2
124 INQ000497031_0064 para 4.3; INQ000572261_0021-0022 paras 99-100
125 Gareth Rhys Williams 5 March 2025 53/1-6
126 INQ000561670_0009 para 38
127 INQ000536362_0036-0037 para 114

1.67. There were instances of NHS trusts panic buying and hoarding ventilator equipment, and competition between trusts drove up prices.[128] The level of concern was such that, according to Professor Ramani Moonesinghe (National Clinical Director for Critical and Perioperative Care at NHS England from March 2020), early in the pandemic clinicians had considered and dismissed "*multiple unusual and innovative ideas to increase ventilator capacity*".[129] This included using ventilators usually designed for veterinary practice and splitting one ventilator between more than one patient.[130] Professor Moonesinghe explained that the need to consider such ideas was "*100%*" due to lack of preparedness to stock sufficient ventilators by the UK government.[131]

1.68. The emergency provision of ventilators and critical care more generally did not feature significantly in the pandemic response exercises, appearing only marginally in Exercise Shipshape (England and Wales, 2003) and Exercise Goliath (Northern Ireland, 2003).[132] However, in 2016, Exercise Cygnus reported that the means of procuring critical care equipment, such as ventilators, was "*robust*".[133] The findings of Exercise Cygnus – in respect of UK ventilator capacity and the UK government's ability to procure ventilators at speed – were not borne out by the reality of the response to the Covid-19 pandemic. The procurement and distribution system for ventilators should have been subject by the Department of Health and Social Care to more rigorous stress-testing, which should have revealed the deficiencies.

Emergency provision of testing equipment

1.69. Procurement for testing involves the purchase of a range of items, from low-value consumables such as swabs and test tubes to highly specialised and expensive technical laboratory equipment and machinery. As a future pandemic may involve a novel pathogen that behaves quite differently from known viruses, suitable tests may not exist or may not exist in a form suitable for population-wide testing. Unlike PPE, testing equipment cannot generally be stockpiled because what is needed may vary between different kinds of pandemics.[134]

1.70. One of Public Health England's key functions for pandemic preparedness and resilience was testing and contact tracing for communicable diseases, but when the pandemic emerged it was not prepared for testing on a population-wide scale.[135] Sarah Collins, Commercial Director at the UK Health Security Agency (the successor to Public Health England) from January 2022 to January 2025, told the Inquiry that Public Health England's remit did not extend to maintaining or establishing "*large*

128 INQ000561670_0004 para 15
129 INQ000518349_0010 para 33
130 INQ000518349_0010 para 33; Ramani Moonesinghe 17 March 2025 135/15-136/1
131 Ramani Moonesinghe 17 March 2025 136/6-8
132 INQ000235217_0004, 0008, 0017; INQ000206664_0015
133 *Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza – 18 to 20 October 2016*, Public Health England, 13 July 2017, p35 (https://data.parliament.uk/DepositedPapers/Files/DEP2020-0621/Exercise_Cygnus_Report.pdf; INQ000056232)
134 INQ000562340_0067 para 162
135 Sarah Collins 13 March 2025 68/12-70/1; *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)

scale" testing capacity and infrastructure.[136] However, neither did Public Health England have any plans for how to procure that increased capacity in the event of an emergency requiring mass testing, despite a framework agreement with the Department of Health and Social Care.[137]

1.71. The February 2018 framework agreement between the Department of Health and Social Care and Public Health England made clear that Public Health England was responsible for:

- protecting the public's health from infectious diseases;
- providing the infrastructure for health protection;
- investigating and managing outbreaks of infectious diseases; and
- ensuring effective emergency preparedness, resilience and response for health emergencies.[138]

Planning and preparedness to establish a scalable system of testing in the event of a pandemic were therefore integral to Public Health England fulfilling these functions. The Department of Health and Social Care was responsible for overseeing Public Health England's fulfilment of its functions and for ensuring that it was sufficiently resourced to do so. Although Public Health England led the testing programme early in the Covid-19 pandemic, in mid-March 2020, the Department of Health and Social Care took responsibility due to a lack of convincing plans to expand testing capacity within Public Health England.[139] The establishment of NHS Test and Trace is being explored in detail in Module 7: Test, trace and isolate.

1.72. While there were means of procuring relatively small volumes of items required for some of Public Health England's usual work, they were inadequate for the procurement of large volumes of testing equipment required during the Covid-19 pandemic.[140] Regular suppliers provided a useful starting point for the National Testing Programme but new suppliers had to be found to increase capacity.[141]

1.73. Public Health England did not have sufficiently developed and appropriately structured relationships with industry bodies to enable it to establish a scalable system of testing in the event of a pandemic. This was despite its responsibility for testing and contact tracing for communicable diseases and in the knowledge that

136 INQ000521972_0013 para 3.15
137 INQ000521972_0013 para 3.15
138 *Framework Agreement between the Department of Health and Social Care and Public Health England: February 2018*, Department of Health and Social Care and Public Health England, February 2018, p5 (https://assets.publishing.service.gov.uk/media/5a757d4a40f0b6360e474848/Framework_agreement_between_DHSC_and_PHE_2018.pdf; INQ000090327); *Framework Agreement between the Department of Health and Social Care and Public Health England: February 2018. Annex A: Public Health England's Statutory Functions*, Department of Health and Social Care and Public Health England, February 2018 (https://assets.publishing.service.gov.uk/media/5a81fb1740f0b6230269a335/Framework_agreement_between_DHSC_and_PHE_2018_Annex_A_statutory_functions.pdf; INQ000090328)
139 INQ000536350_0042-0043 paras 194-197
140 INQ000521972_0010-0011 para 3.7
141 INQ000562340_0055 para 127

it did not have the internal capability. James Bethell, Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021), explained that, although Public Health England had "*fabulous scientists*" who were "*extremely good at the analysis of viruses*", it had "*no ambition*" to put together the kind of population-wide health diagnostics that other countries had ready.[142] He identified several problems, principal among them that Public Health England did not:

> "*have a reach into diagnostic companies in order to source the material, they didn't have a data spine to build on, and nor did they have any local or regional aspect to their test and trace capability*".[143]

1.74. Ms Collins acknowledged that, prior to the Covid-19 pandemic, Public Health England had no major commercial procurement function as it did not anticipate mass testing in response to a pandemic.[144] In the first half of 2020, this hampered the ability of the Covid-19 testing programme to procure on the scale required for mass testing. It limited the opportunities for proactive collaboration between government and the private sector in the development of testing equipment.[145]

1.75. Testing was initially led by Public Health England, before being taken over by the Department of Health and Social Care in mid-March 2020, which then established a new organisation to lead on testing – NHS Test and Trace (established on 28 May 2020).[146] This had specialist leadership and a focus on increasing testing capacity, including through a significantly enhanced capability for procurement and distribution.[147] In the critical earliest stages of the Covid-19 pandemic, valuable time was lost in creating this new body. This was due to a lack of planning and preparedness by the Department of Health and Social Care and Public Health England.

1.76. The scientific innovation that produced tests capable of being deployed at scale and the establishment of a UK-wide population testing programme required collaboration between NHS Test and Trace and industry, as well as significant private and public sector funding. In the *Technical Report on the COVID-19 Pandemic in the UK*, the Chief Medical Officers and Chief Scientific Advisers of the four nations identified the core capabilities required to deliver effective testing at scale across the UK as:

- product development;
- high throughput laboratory capacity;

142 James Bethell 19 March 2025 8/13-16
143 James Bethell 19 March 2025 8/20-24
144 INQ000521972_0010 para 3.2; Sarah Collins 13 March 2025 68/17-22
145 INQ000521972_0083-0084 paras 8.18-8.19
146 INQ000521972_0005-0006 paras 2.7-2.8
147 James Bethell 19 March 2025 8/13-9/2; INQ000521972_0005-0006 para 2.8

- access to a national distribution network; and
- supply chain and logistical expertise.[148]

These capabilities were integral to procurement and distribution but did not form part of the Department of Health and Social Care's or Public Health England's pandemic planning.

1.77. The extent to which mass-testing infrastructure established for the Covid-19 pandemic should be maintained in non-pandemic times is being examined in detail in Module 7: Test, trace and isolate. However, if the procurement and distribution systems for testing equipment are not ready, including in these key areas, they will have to be designed and established quickly.[149] This will take time and resources in the early and critical phase of the response.

1.78. As noted in the Inquiry's Module 1 Report, the outbreak of two viruses this century – severe acute respiratory syndrome coronavirus 1 (SARS-CoV-1, known as SARS) and Middle East respiratory syndrome coronavirus (MERS-CoV, known as MERS) – showed the importance of an effective testing infrastructure in responding to a disease outbreak. In light of the experience of SARS, Dr Philip Mortimer (former Head of Virology at the Public Health Laboratory Service) advised in 2003 that the UK required an integrated public health laboratory infrastructure.[150]

1.79. In May 2015, a major outbreak of MERS occurred in healthcare facilities in South Korea when an infected person returned from the Middle East.[151] A sophisticated network of public and private laboratories to enable the rapid scaling-up of testing was key to South Korea's response to MERS.[152]

1.80. In February 2016, Exercise Alice was conducted in London to explore the challenges that a large-scale outbreak of MERS could present in England. One of its recommendations was the production of a briefing paper on the response in South Korea to MERS, but this was not completed.[153] In January 2018, Exercise Broad Street in England observed that, while northern and southern hubs for testing laboratories would be sufficient, additional laboratories were needed across the UK.[154] As the

148 *Technical Report on the COVID-19 Pandemic in the UK*, Department of Health and Social Care, 1 December 2022, pp190-191 (https://www.gov.uk/government/publications/technical-report-on-the-covid-19-pandemic-in-the-uk; INQ000101642)
149 INQ000521972_0086 para 8.22
150 INQ000205178_0058-0059 para 83; 'Giants on clay feet: COVID-19, infection control and public health laboratory networks in England, the USA and (West) Germany (1945–2020)', C Kirchhelle, *Social History of Medicine* (2022), 35(3), 703-748, p736 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9384317/pdf/hkac019.pdf; INQ000207449); *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
151 INQ000195846_0011 para 40; see also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
152 INQ000177796_0010 para 40; see also *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
153 *Report: Exercise Alice – Middle East Respiratory Syndrome Coronavirus (MERS-CoV)*, Public Health England, 15 February 2016, p11 (https://assets.documentcloud.org/documents/21080373/report-exercise-alice-middle-east-respiratory-syndrome-15-feb-2016.pdf; INQ000090431)
154 *Report: Exercise Broad Street: High Consequence Infectious Disease (HCID) Exercise: 29 January 2018*, Public Health England, April 2018, pp13-14 (https://cygnusreports.org/wp-content/uploads/2021/10/Exercise-Broad-Street-full-report.pdf; INQ000090442)

Inquiry concluded in its Module 1 Report, these and other exercises undertaken across the UK and other information available to the UK government highlighted that a scalable system of testing was needed as part of a suite of epidemiologically sound and effective infection control measures.[155]

1.81. Prior to the Covid-19 pandemic, there was no exercise undertaken for mass testing in the UK.[156] If the pandemic response exercises undertaken by the Department of Health and Social Care, Public Health England and the devolved administrations had included population-wide testing, they would have shown that any such system needed to be underpinned by an effective emergency procurement and distribution system tailored specifically to testing equipment.

1.82. The failure to examine thoroughly the issue of testing in exercises in advance of the Covid-19 pandemic meant that the UK was exposed to the risk of having to create policy, including on the procurement and distribution of testing equipment, during (rather than before) the emergency. This was another missed opportunity. The entirety of the UK's testing and contact tracing system was designed to deal only with small numbers of cases of emerging infectious diseases.[157]

Improving readiness for emergency procurement and distribution

1.83. To be ready for the emergency procurement and distribution of healthcare equipment in a pandemic requires robust, readily accessible stockpiles and the regular stress-testing of procurement and distribution systems.

1.84. In March 2026, the Department of Health and Social Care published the *Pandemic Preparedness Strategy*, in which improvements to stockpile arrangements are planned.[158] This includes specific provision for adult social care, preparing for a range of disease scenarios, implementing 'dynamic' stockpiling (where products are cycled through business-as-usual usage) and ensuring that the stockpiles better reflect the composition of the UK's health and social care workforce.[159] However, some of the proposed improvements may not be implemented until 2030. The Inquiry would like to see even more urgency and action to ensure that the UK is better prepared for the next pandemic.

155 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapters 1, 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
156 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
157 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Chapter 5 (https://covid19.public-inquiry.uk/documents/module-1-full-report)
158 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)
159 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, pp27-29 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)

1.85. A full and well-maintained stockpile is insurance against the effects of the earliest stages of a pandemic. While there are a number of important factors which need to be taken into account, the stockpiles must as a minimum:

- take proper account of the range of pandemic risks identified in the National Security Risk Assessment;
- be weighted in accordance with the National Security Risk Assessment;
- be subject to an effective system of management and oversight; and
- be readily accessible.

Stockpiles across the UK must also be at their target volumes.

1.86. In addition to having robust pandemic stockpiles, the UK government and devolved administrations must be better prepared to procure further supplies of PPE for distribution to the health and social care sectors, to provide ventilators for hospitals, and to increase the procurement and distribution of testing equipment.

Recommendation 1: Improvements to the composition, management and inspection of the pandemic stockpiles

The UK government and devolved administrations should ensure, within 12 months of the publication of this Report, that the pandemic stockpiles:

- retain stock that is better aligned with the range and severity of pandemic risks identified in the National Security Risk Assessment;
- maintain a minimum three-month supply of PPE for the entire health and social care system in the UK;
- retain close-to-zero tolerance for expired stock;
- better reflect the composition of the UK's health and social care workforce, aligned with fit-testing and other sizing requirements;
- maintain a simple and streamlined system of management and oversight; and
- are stored in a wide range of accessible locations.

To demonstrate continued compliance with the above, inspection reports should be submitted to health and social care ministers at least annually. Any issues identified should be resolved within three months.

The inspection reports should be published with the preparedness and resilience reports (Module 1, Recommendation 8).

1.87. Although the UK government and devolved administrations engaged in extensive programmes of pandemic response exercises, these failed to examine adequately their readiness for the emergency procurement and distribution of healthcare equipment. As a result, obtaining value for money, fair competition and integrity were put at risk.

1.88. According to the 2026 *Pandemic Preparedness Strategy*, pandemic response exercises are to be targeted at "*core functions, such as supply chain disruption*".[160] There should be a specific commitment to stress-testing procurement and distribution systems.

1.89. The structures, systems and processes for emergency procurement and distribution must be thoroughly stress-tested in advance to ensure that they are able to withstand the pressure and disruption of a pandemic. As the UK government and devolved administrations cannot stockpile for the possibility of every type of pandemic, a properly stress-tested emergency procurement and distribution system, capable of being adapted and deployed in a future pandemic, is essential.

1.90. The regular, UK-wide pandemic response exercises recommended by the Inquiry in its Module 1 Report (Recommendation 6) should specifically incorporate the procurement and distribution of an appropriate range of essential healthcare equipment.

Recommendation 2: Pandemic response exercises to include emergency procurement and distribution

The UK government and devolved administrations should evaluate the readiness of the structures, systems and processes for the emergency procurement and distribution of healthcare equipment as part of UK-wide pandemic response exercises.

160 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, pp23-24 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)

Chapter 2: Emergency procurement and distribution during the pandemic

Introduction

2.1. Procuring and distributing healthcare equipment during a pandemic is a complex technical challenge. It demands a clear understanding of the necessary equipment, an efficient sourcing strategy and precise logistical operations. These critical calculations must be made amid severe pressures from highly volatile global markets, which dictate the prices, quantities and delivery schedules of available supplies.

2.2. Neither the UK government nor the devolved administrations had adequate systems ready for the emergency procurement and distribution of healthcare equipment when the Covid-19 pandemic emerged. New structures, systems and processes had to be created.

2.3. The focus of this chapter is the critical 100 days for healthcare equipment procurement from 22 March 2020, when the Department of Health and Social Care agreed its first pandemic contract for personal protective equipment (PPE), to 30 June 2020, when the department stopped sourcing new suppliers of PPE to respond to the procurement emergency.[1] During this period, those responsible for public procurement across the UK sought to buy at the necessary speed and scale to respond to the pandemic, while seeking to limit the risk caused by the rapid expenditure of large sums of public money.[2] This chapter examines how the UK government and devolved administrations acted to procure and distribute PPE, ventilators and testing equipment during the pandemic.

Initial response of the central procurement bodies

2.4. The procurement and distribution of healthcare equipment are devolved matters, generally carried out by the central procurement bodies in each of the four nations of the UK. These are Supply Chain Coordination Ltd (in England), which provided the majority but not all of the healthcare equipment and supplies used in the NHS in England, NHS National Services Scotland (known from 1 April 2026 as Public Services Delivery Scotland), NHS Wales Shared Services Partnership and the Business Services Organisation's Procurement and Logistics Service (in Northern Ireland).[3]

2.5. Supply Chain Coordination Ltd is a private company which was wholly owned by the Department of Health and Social Care until 1 October 2021, when it was transferred to NHS England.[4] As mandated by the Department of Health and Social Care, before the Covid-19 pandemic, Supply Chain Coordination Ltd operated a procurement

1 INQ000528391_0190-0191 paras 724-725
2 INQ000528391_0005-0006, 0191 paras 17, 724, Table 10
3 INQ000492085_0018 para 7.3; INQ000521969_0007-0008 para 22
4 Following the abolition of NHS England in 2025, its ownership reverted to the Department of Health and Social Care.

system comprising 11 'towers'.[5] Each tower was responsible for a category of healthcare equipment and supplies and was sub-contracted by Supply Chain Coordination Ltd to separate companies that sourced, purchased and delivered items (including PPE) to NHS trusts in England.[6] These companies were each responsible for developing and implementing a specific strategy to procure the items within their category.[7] The principal aim of Supply Chain Coordination Ltd was to procure healthcare equipment and supplies in sufficiently large volumes that it could sell them at lower prices than suppliers could offer to individual NHS trusts and thus reduce costs.[8]

2.6. Supply Chain Coordination Ltd told the Inquiry that it was "*purely a transacting rather than a decision-making body*".[9] Before the pandemic, it took its instruction from the Department of Health and Social Care, Public Health England and NHS England; during the Covid-19 pandemic, instruction also came from the Army and other UK government departments.[10]

2.7. In England, before and during the pandemic, Supply Chain Coordination Ltd was only one of many suppliers from which NHS trusts could buy healthcare equipment.[11] In Scotland and Wales, healthcare trusts – and in Northern Ireland, Health and Social Care trusts – were reliant on the central procurement bodies for almost all their medical equipment and supplies.[12] NHS National Services Scotland was the procurement arm for the whole of the NHS in Scotland and relied on "*longstanding, trusted relationships with a diverse range of suppliers*".[13] In Wales, NHS Wales Shared Services Partnership benefited from having "*central responsibility for buying, storing, distributing*", as well as "*joined up*" established relationships with suppliers.[14] In Northern Ireland, the Business Services Organisation's Procurement and Logistics Service undertook almost all procurement of PPE and provided advice and support to Health and Social Care trusts, which procured their own healthcare equipment.[15]

2.8. While Supply Chain Coordination Ltd aimed to become the primary supplier – which it considered amounted to 80% of supplies – for all 226 NHS trusts in England, this goal had not been reached by 2020.[16] Prior to the pandemic, it was supplying approximately 50% (113) of NHS trusts.[17] As the demand for healthcare equipment soared globally, Supply Chain Coordination Ltd faced significantly increased demand from the trusts it regularly supplied and demand from the remaining trusts that had never before ordered from it.[18] Supply Chain Coordination Ltd experienced

5 INQ000492085_0005-0006 para 3.9
6 INQ000492085_0005-0006, 0013-0014 paras 3.9, 5.1-5.10
7 INQ000492085_0005-0006 para 3.9
8 INQ000492085_0015, 0017-0019 paras 5.13, 7.2, 7.7
9 INQ000492085_0005 para 3.12
10 INQ000492085_0004-0006 paras 3.3-3.7, 3.12
11 INQ000409265_0007 paras 5.1-5.2
12 INQ000531855_0002 para 3; INQ000536425_0004-0005 paras 15-17; INQ000514103_0007 para 12
13 INQ000531855_0002 para 3
14 Alan Brace 11 March 2025 194/7-14
15 Karen Bailey 26 March 2025 4/13-20; INQ000514103_0007 para 12
16 INQ000492085_0004 para 3.2
17 INQ000659765_0008 para 31
18 INQ000492085_0022 para 7.25; INQ000528391_0038 para 130

an approximate increase of 4,500% in demand for alcohol hand gel, reflective of broader sharp spikes in demand for PPE and other healthcare equipment.[19] This was not limited to PPE but across all 600,000 products supplied by Supply Chain Coordination Ltd.[20] Its staff believed there was panic ordering, with trusts ordering more than they needed.[21]

2.9. The Department of Health and Social Care did not design or require Supply Chain Coordination Ltd to be prepared to meet the needs of all NHS trusts in England in non-pandemic times, much less the demands of the UK's health and social care sectors in their entirety at the same time and in conditions of extreme urgency.[22]

2.10. In January 2020, on instruction from the Department of Health and Social Care's Emergency Preparedness, Resilience and Response Team and in parallel with a gradual release of PPE from the stockpile, orders for PPE from NHS trusts were cancelled, requests were triaged and PPE was allocated in an attempt to distribute it fairly.[23] From 31 January 2020, in reaction to the scale of the problem, Supply Chain Coordination Ltd, with the agreement of NHS England, instituted "*demand management*", effectively rationing the supply of PPE.[24]

2.11. In comparison with Supply Chain Coordination Ltd, the central procurement bodies in Scotland, Wales and Northern Ireland were better able to scale up their procurement and distribution operations during the pandemic. This was principally due to differences in population sizes and structural differences between the organisations.

2.12. The differences in the sizes of their populations meant that the volume of PPE and other healthcare equipment and supplies demanded by the healthcare sector was significantly larger in England (approximately 56.5 million people) than in Scotland (approximately 5.5 million people), Wales (approximately 3 million people) or Northern Ireland (approximately 1.8 million people).[25]

2.13. There were differences in the scale of Supply Chain Coordination Ltd's response compared with the central procurement bodies in Scotland, Wales and Northern Ireland. In England, Supply Chain Coordination Ltd spent approximately £5.2 billion on PPE (with an additional £8.6 billion spent by the Department of Health and Social Care). In Scotland it was £446 million, in Wales £385 million and in Northern Ireland £419 million.[26] The responsibility for sourcing PPE was significantly greater for Supply Chain Coordination Ltd as compared with the other central procurement bodies across the UK.

19 INQ000533076_0001 para 3
20 INQ000492085_0022 para 7.25
21 Emily Lawson 11 March 2025 16/5-18
22 INQ000492085_0056-0057 row 4
23 INQ000492085_0023 para 7.28
24 INQ000492085_0023-0024 paras 7.27-7.32
25 INQ000660145_0015-0016
26 INQ000528391_0005-0006 para 17; INQ000512475_0005 para 19; INQ000514103_0059 para 182; INQ000498835

2.14. Supply Chain Coordination Ltd was established for "*predictable worlds*" and "*efficiency*" in non-pandemic times, but its complex structure and operating model meant that it lacked the control, agility and ability needed for pandemic procurement.[27] The structure and operating model of Supply Chain Coordination Ltd as primarily a transacting body meant that it was unable to adapt quickly enough to sharp increases in demand. The tower system, imposed on it by the Department of Health and Social Care to save money, meant that Supply Chain Coordination Ltd did not have direct relationships with suppliers and there were more parties in its supply chains than in the devolved administrations' central procurement bodies. This was an unwieldy system which was less adaptable than its counterparts in the devolved administrations. It was ill-suited to respond to the Covid-19 pandemic.[28]

2.15. The capacity of Supply Chain Coordination Ltd to respond adequately was limited by the business continuity preparations of its sub-contractors, which it had approved but which were insufficient for the Covid-19 pandemic.[29] Public Health England had not specifically given Supply Chain Coordination Ltd the task of putting in place pandemic-specific plans – there was no pandemic 'playbook'.[30]

2.16. When Covid-19 emerged, Supply Chain Coordination Ltd was in the midst of transferring to the responsibility of NHS England.[31] It was also operating with outdated technology and undergoing an IT systems upgrade.[32] The reorganisation and poor data and technology systems contributed to Supply Chain Coordination Ltd not having, for example, ready visibility over stock, demand or delivery schedules for healthcare equipment. Its systems were prone to cancelling orders when, as was common especially in the early stages of the pandemic, demand outstripped supply, and it was ill-equipped quickly to suggest alternative suppliers of PPE to NHS trusts that desperately needed it.[33]

2.17. The different purpose, structure and systems of Supply Chain Coordination Ltd were in marked contrast to the devolved administrations' simpler, more streamlined and direct relationships with suppliers. Together with its lack of overall readiness, these had a material impact on its ability to respond effectively.[34]

2.18. The devolved administrations' central procurement bodies did not require direct government intervention to increase their procurement and distribution operations.

27 INQ000560895_0025 para 78; INQ000347820_0001; INQ000492085_0059-0060 paras 19.9.1-19.9.3
28 INQ000539153_0059 summary box 15, bullet 3
29 INQ000492085_0029 paras 9.3-9.4
30 Paul Webster 11 March 2025 123/23-124/25; INQ000492085_0059 para 19.9.1
31 Emily Lawson 11 March 2025 4/7-13; Paul Webster 11 March 2025 98/1-12
32 INQ000492085_0060 para 19.9.5; Phillip Prosser 26 March 2025 160/21-161/22
33 INQ000492085_0025, 0027 paras 7.34, 7.36, 7.44
34 INQ000549346_0015; INQ000521969_0001-0002 paras 3-6; INQ000531855_0002 para 3; INQ000498141_0003 para 6; INQ000536425_0002, 0011 paras 5-6, 47

Structures, systems and processes established during the pandemic

2.19. The UK government responded to the challenges of emergency procurement and distribution by establishing:

- a PPE Cell, within the Department of Health and Social Care, to supplement Supply Chain Coordination Ltd's procurement operation;
- an Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme, run jointly by the Department of Health and Social Care and NHS England, to procure ventilators, oxygen and related critical care equipment; and
- NHS Test and Trace, a new body, to procure testing equipment.

Procurement and distribution of PPE

Procurement

2.20. In early March 2020, NHS England became aware from NHS trusts that PPE orders they were making through the Supply Chain Coordination Ltd tower structure were not arriving on time. On 10 March 2020, Sir Simon Stevens, later Lord Stevens of Birmingham (Chief Executive of NHS England from April 2014 to July 2021) asked Emily Lawson, later Dame Emily Lawson (National Director for Transformation and Corporate Operations at NHS England (and, from April 2018, NHS Improvement) from November 2017 to April 2020), to investigate. The investigation confirmed the reports – critical PPE was not arriving at NHS trusts, either on time or at all.[35]

2.21. When the issues with Supply Chain Coordination Ltd became clear, the Department of Health and Social Care established the PPE Cell. This was a group of dedicated teams of officials overseen by the department, responsible for procuring and distributing PPE.[36]

2.22. The PPE Cell brought together officials from across government, the healthcare system and the Army. They were organised into three key teams, each with a specialist remit:[37]

- 'China Buy' (a team in the Department of Health and Social Care), to procure directly from manufacturers and distributors in China;
- 'UK Make' (a joint programme between the Department of Health and Social Care and the Department for Business, Energy and Industrial Strategy), to scale up domestic manufacturing; and

35 INQ000533074; INQ000531295_0008-0009 paras 35-39; INQ000528585_0043 para 204
36 INQ000528391_0004 para 12
37 INQ000528391_0004 para 12

- 'New Buy' (also known as 'New Opportunities'), to consider offers from other suppliers.[38]

The PPE Cell operated with Supply Chain Coordination Ltd, which procured PPE from regular suppliers.[39]

2.23. The new structures were created in March 2020 in an intensely pressured environment – described by officials as "*frenetic*" and "*chaotic*" as they established new systems and processes while procuring PPE for health and social care workers.[40] As Andy Wood (Deputy Director, Commercial Specialist in the Cabinet Office and Lead for the PPE Buy Cell, a sub-set of the PPE Cell, from March to July 2020) explained, "*we had to build the aeroplane as we were flying it*".[41]

2.24. Mr Wood described the scale of the crisis as such that, on his first day, 21 March 2020, his team was briefed to "*buy as much PPE as we possibly could because people were dying*".[42] This was confirmed by Sir Mark Sedwill, later Lord Sedwill (Cabinet Secretary and Head of the Civil Service from October 2018 to September 2020) on 23 April 2020, who explained that Boris Johnson MP (Prime Minister from July 2019 to September 2022) would take a "'*whatever it takes' approach on PPE, including purchasing at risk, longer term contracts and investment in domestic production capacity if necessary*".[43]

Distribution

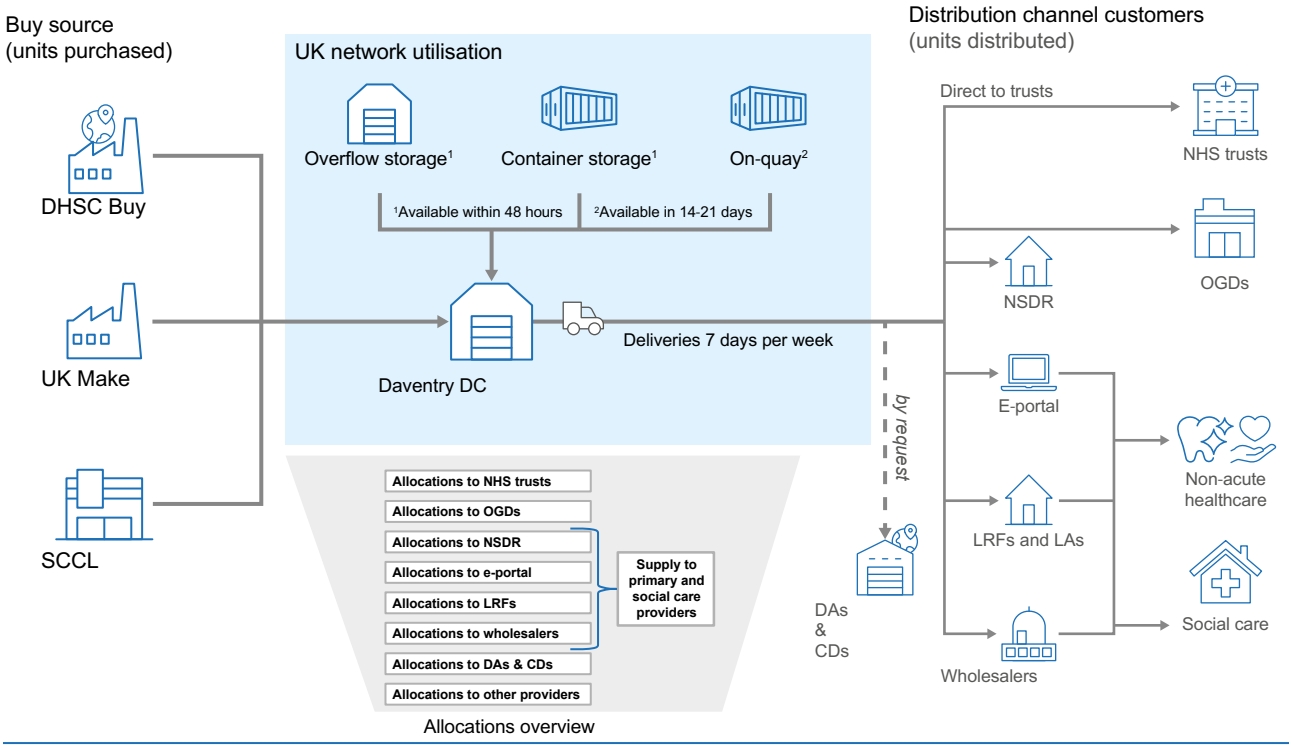
2.25. As Supply Chain Coordination Ltd deployed the pandemic stockpile and the procurement and distribution of PPE sharply increased, the distribution centres in England came under strain.[44] On 18 March 2020, Unipart (a specialist logistics company contracted prior to the Covid-19 pandemic by the UK government to supply its services in the event of an emergency) warned that the layout, shortages of space and staffing of its distribution centres would not allow for any further increases in the volume of PPE it was able to process.[45] It informed Ms Lawson and Sir Gareth Rhys Williams (UK Government Chief Commercial Officer from March 2016 to July 2024) of these issues.

2.26. Over the next few days, Ms Lawson sought military assistance.[46] On 20 March 2020, Major General Phillip Prosser (Brigadier Commander of the 101 Logistic Brigade) was deployed to a PPE team within NHS England and the Army joined the effort to assist with organising and coordinating the logistics and distribution of PPE in

38 INQ000528391_0005 para 13
39 INQ000528391_0005 para 13
40 Darren Blackburn 6 March 2025 66/19-67/3-6, 87/14-16; Andy Wood 6 March 2025 161/5-10, 163/13-16, 164/17
41 Andy Wood 6 March 2025 164/18-19
42 INQ000540488_0061-0062 paras 12.3-12.4
43 INQ000528391_0086 para 320; INQ000551587
44 Phillip Prosser 26 March 2025 138/8-12, 140/10-12
45 INQ000572261_0031 para 140
46 INQ000572261_0032 para 143

England.[47] It was a formidable task (see Figure 2). Major General Prosser explained that distribution centres, where the task of physically breaking down large pallets of PPE to repackage them into smaller packages that could be distributed to NHS trusts took place, were "*clogged*", making it "*harder to get stuff into the distribution centres and then harder to get it out*".[48]

Figure 2: Overview of UK PPE procurement and distribution, Department of Health and Social Care, September 2020



Source: *INQ000551751_0015*

2.27. To assist with logistics and distribution, on about 24 March 2020, another logistics company – Clipper Logistics plc – was contracted to support Unipart.[49] Clipper Logistics plc established a larger warehouse in Daventry, Northamptonshire, principally to store and process imported PPE. The Inquiry was told that this helped to stabilise the distribution system by allowing PPE supplies to be more smoothly and quickly received, inspected, packed and distributed.[50]

2.28. In Scotland, in April 2020, National Procurement (a body within NHS National Services Scotland tasked with ensuring that critical supplies were available and distributed to NHS Scotland) expanded its PPE storage from one to three sites, improving distribution capacity and efficiency with new warehouses and an inventory management system.[51]

47 INQ000560895_0004 para 12
48 Phillip Prosser 26 March 2025 140/8-12
49 Phillip Prosser 26 March 2025 165/12-16
50 INQ000538647_0010 para 28; INQ000569125_0006 para 30
51 INQ000521969_0033, 0068 paras 121-123, 284; INQ000502630_0007-0014

2.29. The Welsh Government faced initial challenges with warehouse capacity, moving stock to a large warehouse and using existing networks and food distributors for distribution.[52]

2.30. Only in Northern Ireland did the central procurement body, the Business Services Organisation's Procurement and Logistics Service, use its existing warehouse management system effectively, with only a few reported capacity issues.[53]

Obtaining and distributing ventilators

2.31. The Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme was established jointly by the Department of Health and Social Care and NHS England on 3 March 2020.[54] Supply Chain Coordination Ltd held a number of standard framework agreements (agreements with suppliers that set the terms for future purchases of goods and services) for the provision of ventilators. Requests for available ventilators went to suppliers on 4 March, with the first contracts placed on 9 March. However, this route was largely exhausted by 12 March.[55]

2.32. That same day, Mr Johnson, Matt Hancock MP (Secretary of State for Health and Social Care from July 2018 to June 2021), Michael Gove MP, later Lord Gove (Chancellor of the Duchy of Lancaster from July 2019 to September 2021) and senior officials in the Cabinet Office and the Department of Health and Social Care agreed that significant additional support from across government for the provision of ventilators was required.[56] As a result, it was decided that:

- The Foreign and Commonwealth Office would be mobilised to support the purchase of ventilators from overseas manufacturers and distributors.
- The Ministry of Defence would offer additional support on procurement, logistics and transportation.
- The Cabinet Office would lead on ramping up domestic manufacture of ventilators – a drive which would become the 'Ventilator Challenge'.[57]

2.33. By 3 August 2020, as a result of the overall ventilator procurement efforts, more than 30,000 ventilators were available to healthcare systems across the UK. The procurement of these ventilators, including their quality, is considered further in Chapter 4: Global supply chains and domestic industrial resilience.

52 INQ000536425_0034 para 142
53 INQ000514103_0026, 0039, 0058, 0068-0069 paras 61, 110, 177, 209-213
54 INQ000561670_0004-0005 paras 16-17
55 INQ000561670_0015 para 61
56 INQ000497031_0065 para 4.5
57 INQ000561670_0015-0016 paras 66-67

2.34. All centrally procured ventilators were held by NHS England to be distributed and redistributed as required across the UK, to areas with the most immediate need based on patient numbers.[58]

2.35. On 2 April 2020, NHS England established the National Ventilation Allocation Panel with representation from the regions. The panel was chaired by Professor (later Sir) Keith Willett (Covid Incident Director at NHS England from January 2020), attended by senior representatives from each NHS region (such as medical directors) and supported by representatives of the Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme.[59] It initially held daily meetings to prioritise and allocate equipment to NHS trusts in England based on urgent clinical need, as well as to challenge and review such decisions.[60] Chris Stirling (Programme Director of the Covid Oxygen, Ventilation, Device and Clinical Consumable Response from March 2020 to September 2021) described the National Ventilation Allocation Panel as:

> "*a relatively unemotional, data-driven system that helped reduce the pressure in a highly charged and emotional environment*".[61]

2.36. This was a sensible response in difficult circumstances. However, one drawback of the National Ventilation Allocation Panel system for clinicians was that, where the allocation process indicated that a particular trust needed ventilators, clinicians could not specify the make or model of ventilator they would like.[62] As the British Medical Association told the Inquiry, clinicians are trained to work with specific models of ventilator, which had implications for the efficacy of rapid ventilator procurement processes during the Covid-19 pandemic.[63] Professor Ramani Moonesinghe (National Clinical Director for Critical and Perioperative Care at NHS England from March 2020) told the Inquiry that clinicians using unfamiliar equipment like ventilators increased the pressure under which they were working and posed a potential risk to patient safety.[64]

2.37. In Scotland, available ventilators were assessed by NHS Scotland clinicians and a small number manufactured by brands familiar to NHS Scotland were accepted to reduce the risk of unfamiliar equipment.[65] Caroline Lamb, Director General for Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland from January 2021, told the Inquiry:

58 INQ000528585_0065 para 295
59 INQ000561670_0023 para 113
60 INQ000528585_0066 para 300; INQ000561670_0023 paras 112-114
61 INQ000561670_0024 para 120; see also INQ000528585_0066 para 301
62 INQ000528585_0069 para 312
63 INQ000562457_0089 para 285
64 INQ000518349_0047 para 187
65 INQ000498141_0129 para 324

> "*This meant that staff working under extreme pressure were not also having to learn to work with new specialised equipment and enabled the equipment to be utilised by* [Health] *Boards post-Covid.*"[66]

This is considered further in Chapter 4: Global supply chains and domestic industrial resilience.

NHS Test and Trace

2.38. The reality of the UK's lack of planning for mass testing became evident at a meeting in the Department of Health and Social Care on 18 March 2020 chaired by James Bethell, Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021). Professor Sir John Bell, Regius Professor of Medicine at the University of Oxford from 2002 to March 2024, explained that the UK's testing capacity was approximately 2,000 to 3,000 tests per day.[67] It was to be increased rapidly to 100,000 to begin population-level testing.[68]

2.39. As a result, the Department of Health and Social Care set up the National Testing Programme in mid-March 2020.[69] The testing programme was predominantly carried out on a four-nations basis.[70] Dr Beverley Jandziol (Commercial Specialist in the Complex Transactions Team at the Cabinet Office from September 2019 to May 2022) was appointed to lead the commercial side of the National Testing Programme and external advisers were to support the growing procurement function.[71] By 4 April 2020, the commercial operation of the testing programme was described internally as organised into five 'pillars' or workstreams:

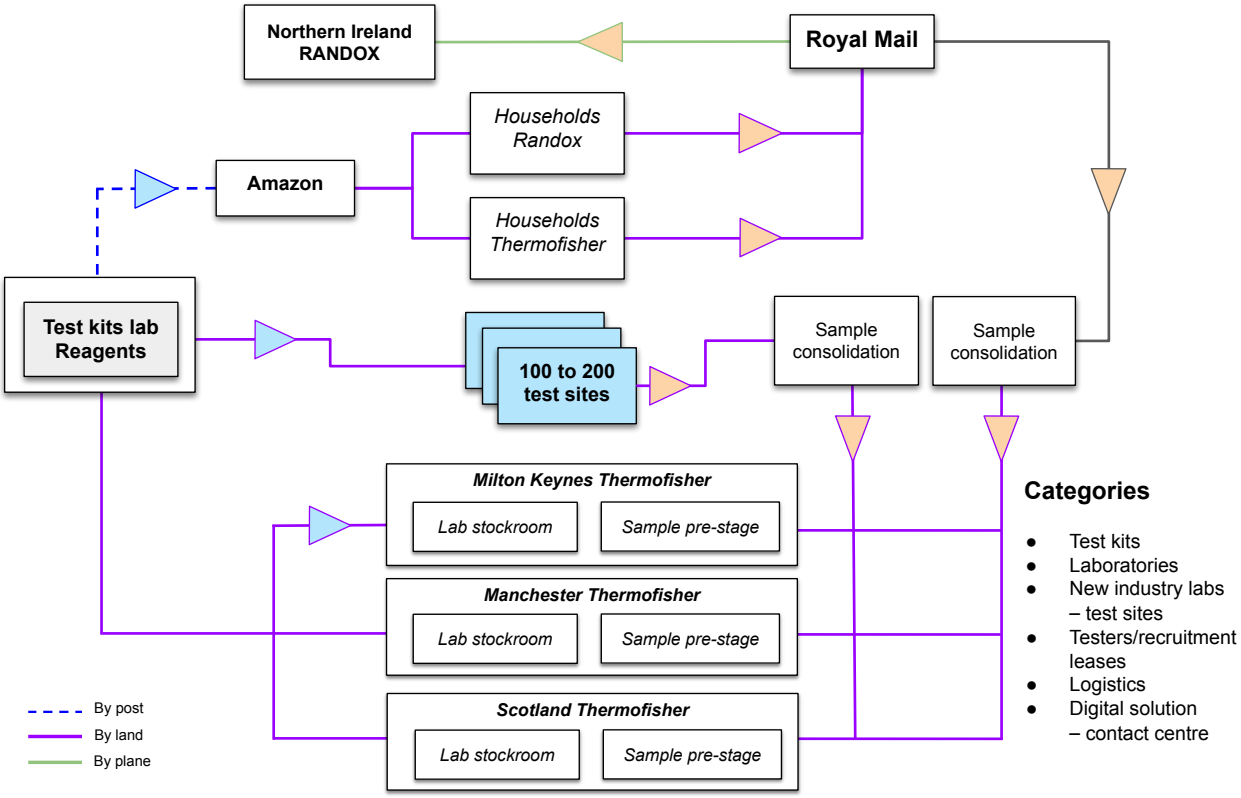
- Pillar One: the procurement of consumables (eg swabs and reagents) and machinery for existing NHS testing capacity;
- Pillar Two: the procurement of additional third-party testing capacity;[72]
- Pillar Three: mass antibody testing to determine levels of immunity to Covid-19;
- Pillar Four: surveillance testing to learn more about the characteristics of Covid-19; and

66 INQ000498141_0126 para 314
67 INQ000562340_0007 para 11b-d
68 INQ000535738
69 INQ000521972_0005-0006 para 2.7
70 INQ000521972_0006 para 2.10
71 INQ000562340_0007-0008, 0011-0014, 0058 paras 11d, 13f-17, 135-136
72 INQ000535762_0001 para 1; INQ000562340_0015 para 19b

- Pillar Five: the National Diagnostics Effort, aimed at mobilising the domestic life sciences industry quickly to build diagnostics infrastructure in the UK and to generate innovative solutions to the limitations of available testing technology.[73] This led to the development of a domestic manufacturing base for lateral flow tests (see Chapter 4: Global supply chains and domestic industrial resilience).[74]

2.40. The testing programme became NHS Test and Trace on 28 May 2020.[75] NHS Test and Trace had to build an entirely new mass-testing infrastructure, which required the procurement of laboratory capacity, testing sites, staff and a specialist distribution network (see Figure 3).[76] Consumables arrived separately and needed to be assembled into testing kits and distributed in varying quantities to testing sites and healthcare facilities.[77] Completed test samples needed to be quickly, hygienically and securely returned to laboratories. Later, consumables were assembled into testing kits and shipped in smaller quantities to a wide range of locations, including pharmacies, workplaces, schools and homes, and were often returned by post.[78] At its height, testing kits were being delivered to approximately 2,000 locations across the UK.[79]

Figure 3: NHS Test and Trace overview



Source: INQ000561740_0002

73 INQ000535762_0001 para 1; INQ000562340_0016 para 19e
74 INQ000521972_0052 para 4.159
75 INQ000521972_0005-0006 para 2.8
76 INQ000521972_0065 para 5.3
77 INQ000521972_0069-0070 para 5.21
78 INQ000521972_0065-0066 paras 5.3-5.10
79 INQ000521972_0066 para 5.10

2.41. This was a new, unplanned and yet major procurement and distribution operation which had to be established rapidly during the Covid-19 pandemic. NHS Test and Trace is being considered by the Inquiry in Module 7: Test, trace and isolate.

Key weaknesses in emergency procurement and distribution

2.42. Although the procurement and distribution systems for PPE, ventilators and testing equipment were established quickly, valuable time was lost by their not being ready in March 2020. Despite the best efforts of those responsible, working under immense pressure, these systems were beset by several weaknesses. Principal among these were:

- the absence of an effective system to triage offers;
- inefficient PPE procurement processes;
- limited capacity to distribute to the social care sector;
- poor integration of PPE procurement and distribution; and
- lack of coordination between governments across the UK.

No effective system to triage offers

2.43. As a result of difficulties in sourcing healthcare equipment, caused by increased global demand and the breakdown in supply chains (see Chapter 4: Global supply chains and domestic industrial resilience), 'calls to arms' were used by the UK government to appeal to potential suppliers and manufacturers of key healthcare equipment to offer their assistance. These calls to arms were either open-source invitations to the public, proactive approaches to selected suppliers and manufacturers or both.[80]

2.44. Calls to arms were made for ventilators (in what became known as the Ventilator Challenge), PPE and testing equipment.

The Ventilator Challenge

2.45. On 12 March 2020, a public 'call to arms' for support in manufacturing ventilators for use across the UK was agreed. It was facilitated by the Department for Business, Energy and Industrial Strategy and formally announced by Mr Johnson on 16 March 2020.[81] Mr Johnson convened a meeting with approximately 60

80 INQ000497031_0157 para 4.346
81 'PM call with UK's leading manufacturers', Prime Minister's Office, Department for Business, Energy and Industrial Strategy and Boris Johnson, 16 March 2020 (https://www.gov.uk/government/news/pm-call-with-uks-leading-manufacturers-16-march-2020; INQ000562749)

leading manufacturers and suppliers of healthcare equipment to encourage them to participate in the Ventilator Challenge, to provide the names of further companies that could assist and to propose design ideas.[82] Sir Gareth Rhys Williams told the Inquiry that this group was a targeted mix of medical device companies, design companies and "*the people who were likely to be able to help*" scale up the rapid production of ventilators.[83] This was thought to be a proactive and strategic approach to sourcing potential suppliers.

2.46. As part of the Ventilator Challenge, also on 16 March 2020, the Department for Business, Energy and Industrial Strategy issued a public call for assistance to make ventilators. Between 18 and 20 March, approximately 700 offers of supply were received, only 40 of which were deemed worthy of follow-up.[84] By 8 May 2020, some 5,300 offers had been received in response to this wider request for help.[85]

2.47. As a result of this open-source approach, the Ventilator Challenge team was:

> "*receiving too many ad hoc requests on which they are being chased which often are for products which don't meet the technical specifications or are bogus*".[86]

Although there were efforts to set up email addresses and specific points of contact to triage and identify the most promising offers, both the Cabinet Office and the Department for Business, Energy and Industrial Strategy were unable to cope with the volume of responses. Sir Gareth Rhys Williams told the Inquiry that, because it was considered necessary to process all the offers in order to ensure that a "*nugget*" was not missed, dealing with the volume of offers "*nearly broke the back of the team*".[87] This approach was also recognised as being inefficient. Another senior official warned: "*These emails are consuming the team – and most of the time come to nothing.*"[88]

Personal protective equipment

2.48. On 23 March 2020, Cabinet Office officials warned the Department of Health and Social Care, including Mr Hancock's Private Secretary, against making a call to arms for PPE unless there was a proper system for triaging offers in place.[89] It anticipated that the number of offers to supply PPE would be very large, that potential suppliers would complain to ministers, MPs and officials that the system was not functioning properly, and that managing these complaints would distract the UK government and impede the primary task of procuring PPE. The Cabinet Office suggested that, should

82 INQ000497031_0070 para 4.33
83 Gareth Rhys Williams 5 March 2025 61/1-24
84 INQ000536362_0011 para 31; 'Call for businesses to help make NHS ventilators', Department for Business, Energy and Industrial Strategy, 16 March 2020 (https://www.gov.uk/government/news/production-and-supply-of-ventilators-and-ventilator-components; INQ000471044)
85 INQ000478812_0002
86 INQ000536362_0013 para 35; INQ000513565_0002
87 Gareth Rhys Williams 5 March 2025 62/3-20
88 INQ000528200_0001; INQ000536362_0010 para 30
89 INQ000536362_0011-0012 para 32; INQ000528203_0001

a PPE call to arms go ahead, there should be a clear point of contact for potential suppliers, a standardised response to offers emphasising the need for patience, and advance publication of the technical specifications for PPE to increase the likelihood of compliant offers being made.[90] Sir Gareth Rhys Williams described this as a "*pretty forthright*" warning.[91]

2.49. Notwithstanding the advice, at the end of March 2020, Mr Hancock and Mr Johnson decided that there needed to be a call to arms for PPE.[92] Mr Hancock told the Inquiry that, although he appreciated the pressure put on the procurement system by a call to arms, in his judgement it was needed to generate more offers of PPE supply.[93]

2.50. On 10 April 2020, Mr Hancock issued a call to arms for the supply of PPE on behalf of the UK government.[94]

2.51. As Sir Gareth Rhys Williams told the Inquiry, while he could see why ministers "*felt it needed to happen*", the very large number of offers put the procurement system under "*extreme stress*".[95] He said:

> "[A] *lot of the problems … flow as much from that as they did from our lack of stock to start with.*"[96]

2.52. While the call to arms may have had in mind the "*Dunkirk spirit*" of citizens coming to the rescue in an emergency, it did not have the desired effect.[97] If anything, "*it made matters a lot worse*".[98] Officials were inundated with offers.[99] Approximately 25,000 offers of PPE were received from 15,000 suppliers in a period of approximately 15 weeks.[100] Within the first week of the online portal for PPE offers being opened on 30 March 2020, there were approximately 3,000 offers.[101] In June 2020, during peak periods, more than 300 new offers were received every 24 hours.[102] The procurement system was "*deluged*", unable to process the vast number of responses.[103]

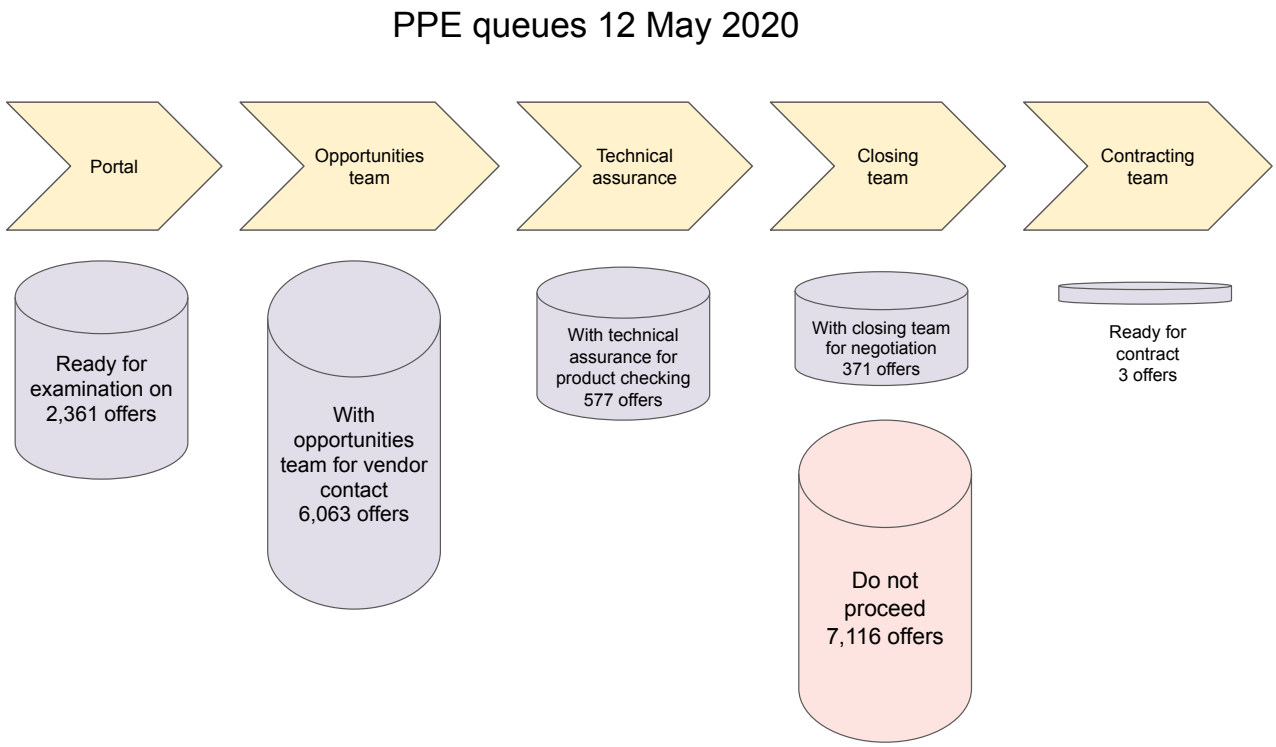
2.53. Mr Wood told the Inquiry that the call to arms was:

> "*not a commercial decision. It gave us a huge problem of trying to assess an avalanche of offers.*"[104]

90 INQ000536362_0011-0012 para 32
91 Gareth Rhys Williams 4 March 2025 197/4-198/19
92 INQ000536362_0011 para 32
93 Matt Hancock 19 March 2025 82/5-20
94 INQ000086580_0005-0006; Gareth Rhys Williams 4 March 2025 198/1-21
95 Gareth Rhys Williams 4 March 2025 186/21, 197/9-10
96 INQ000497031_0010-0011 para 1.29; Gareth Rhys Williams 4 March 2025 186/20-22, 197/9-14
97 Max Cairnduff 6 March 2025 46/3-10
98 Chris Hall 6 March 2025 115/18
99 Matt Hancock 19 March 2025 80/6-9
100 INQ000497031_0010-0011 para 1.29
101 INQ000497031_0010-0011 para 1.29
102 INQ000497031_0010-0011 para 1.29
103 Max Cairnduff 6 March 2025 14/5-20
104 INQ000540488_0062 para 12.7

The triaging and processing of offers to narrow them down was resource-intensive.[105] There were considerable backlogs. By way of illustration, on a single day in May 2020, approximately 2,400 offers were ready for examination, 6,063 offers were being assessed, and 577 were with the technical assurance team (see Figure 4). Of those cases that had reached the closing team, approximately 7,000 had been assessed as unsuitable to pursue and only 371 were in active negotiations. Only three offers were in the process of being awarded a contract.

Figure 4: Fall-out rate for PPE offers



Source: INQ000497031_0164

2.54. At each stage of the process, there was a narrowing of the pool of offers (see Figure 5).[106] A large proportion of offers were found not to be credible.[107] Only a very small percentage of offers resulted in a contract being awarded, demonstrating just how much work was involved in assessing and narrowing down offers of supply.

105 Max Cairnduff 6 March 2025 14/5-20
106 INQ000497031_0164
107 INQ000497031_0010-0011, 0164 paras 1.29, 4.371

Figure 5: Cabinet Office analysis of rejection reasons for offers

Source: INQ000497031_0191-0192

2.55. Despite low conversion of offers to contracts and the resources required to triage and process them, Mr Hancock considered that, on balance, the public calls to arms were the correct and responsible approach because any increase in the number of offers of PPE was worth having.[108] However, as Sir Gareth Rhys Williams explained:

> "[T]*he yield from the offers generated through the call to arms rather than getting the industry into a room, which is what we did with ventilators, I suspect was marginal.*"[109]

2.56. In Scotland, Ivan McKee MSP (Minister for Trade, Investment and Innovation in the Scottish Government from June 2018 to December 2020) appealed to Scottish companies for support with the supply of PPE on 22 March 2020.[110] The number of email responses received meant that National Procurement was "*inundated*" with

108 Matt Hancock 19 March 2025 83/17-22; INQ000536350_0050-0051 para 231
109 Gareth Rhys Williams 4 March 2025 197/15-23
110 INQ000498141_0066 para 216

offers, leading to mailbox capacity issues.[111] To manage this, the online Supplier Office Portal (which used ServiceNow, a cloud computing platform) was launched on 17 April 2020. This became the single entry point for offers and automated and streamlined the process of identifying suppliers' capabilities, including the products they could supply, quantities available, compliance standards met and prices offered. Health boards were encouraged to direct suppliers to this portal.[112] Only one offer was progressed to contract by NHS National Services Scotland, which Gordon Beattie (Director of National Procurement at NHS National Services Scotland from December 2019) said reflected "*the level of scrutiny applied*" to unsolicited offers.[113]

2.57. In Wales, on 3 April 2020, Mark Drakeford MS (First Minister of Wales from December 2018 to March 2024) issued a call to Welsh businesses for PPE manufacturing assistance.[114] The Life Sciences Hub Wales supported this with an online event and liaised with its network of health and life sciences organisations across Wales.[115] Business Wales's website collected data and the Life Sciences Hub Wales triaged offers. The Life Sciences Hub Wales launched an online portal which required suppliers to provide information as part of submitting an offer, including technical specifications and evidence of compliance with technical regulations.[116] Suppliers had three days to respond to queries about regulatory compliance. Goods were checked for regulatory compliance at the Surgical Materials Testing Laboratory prior to the award of a contract. Suppliers had to respond to follow-up queries from the Surgical Materials Testing Laboratory within 24 hours.[117] The Life Sciences Hub Wales was, however, "*overwhelmed with enquiries*" and was "*struggling to cope with demand*", leading to confusion and delays of up to 10 days in triaging offers.[118] A total of only 35 contracts for the supply of PPE were awarded by NHS Wales Shared Services Partnership, two of which were subsequently terminated.[119]

2.58. The Northern Ireland Executive and the Business Services Organisation's Procurement and Logistics Service also made a call to arms for PPE.[120] The Business Services Organisation's Procurement and Logistics Service used the same system for triaging offers regardless of their provenance and did not report experiencing difficulties with the volume of offers it received.[121] It worked with the Medicines Optimisation Innovation Centre, a regional research and development body, which conducted technical and clinical assessments for new suppliers before prices were negotiated or orders were placed.[122] Exceptions were made for certain local

111 INQ000498141_0067 para 220; INQ000521969_0040-0042 paras 151, 157
112 INQ000521969_0024, 0042 paras 88, 159
113 INQ000521969_0040, 0042 paras 151, 159-160
114 'First Minister's call to action for business: Help us provide PPE to frontline NHS staff', Welsh Government, 3 April 2020 (https://www.gov.wales/first-ministers-call-action-business-help-us-provide-ppe-frontline-nhs-staff; INQ000505374)
115 INQ000527715_0008 para 40
116 INQ000512453
117 See the process map at INQ000512459
118 INQ000506526
119 INQ000575089_0012-0013 para 49
120 INQ000534957_0007 para 26; INQ000514103_0026-0027 para 62
121 INQ000514103_0033-0034, 0047 paras 85-86, 132; Karen Bailey 26 March 2025 18/16-19/12, 20/1-16
122 INQ000521964_0061-0062 paras 197-199

manufacturers, allowing contracts prior to approval provided their sample products passed a technical and clinical assessment.[123]

2.59. The experiences across the UK of a call to arms approach to the sourcing of PPE demonstrate that, while they may galvanise industry and the public to offer help in times of national crisis, they should be issued cautiously and only when adequate infrastructure is in place to triage offers effectively. This approach would also help in evaluating unsolicited supply offers, particularly when public concerns about supply are known (see Chapter 7: Data, technology and the future of emergency procurement).[124]

2.60. If future calls for assistance are going to be issued without adequate infrastructure, they are better targeted to the specialist sectors or sections of industry that are judged likely to be able to assist. There should have been a strategic, proactive and selective sourcing of potential suppliers. If there was to be an open call for assistance, it ought to have been established only if it could be supported by a data-driven, automated system of triage.[125] As examined in Chapter 6: Transparency, governance and accountability, the High Priority Lane was set up and continued to operate to address the concern among officials and ministers that, in the earliest stages of the pandemic, good-quality offers of PPE were not being identified and processed quickly enough.[126] The potential for an automated system of triage for emergency procurement is considered in Chapter 7: Data, technology and the future of emergency procurement.

Testing equipment

2.61. As the National Testing Programme could not rely on Public Health England's existing contracts and suppliers, on 8 April 2020 it issued a call to arms to the UK diagnostics industry and followed up by holding virtual webinars with industry representatives.[127] Lord Bethell described three main problems with this approach:

- There was an operational issue, in that government was "*not very good*" at putting up a web portal in the ways that a "*tech start-up might do very easily*".[128]
- Industry was not used to working closely with government in this way and lacked the expertise to respond effectively.
- In the early stages, the UK government did not know what it needed and took time to build an understanding of the industry and the equipment it could provide.[129]

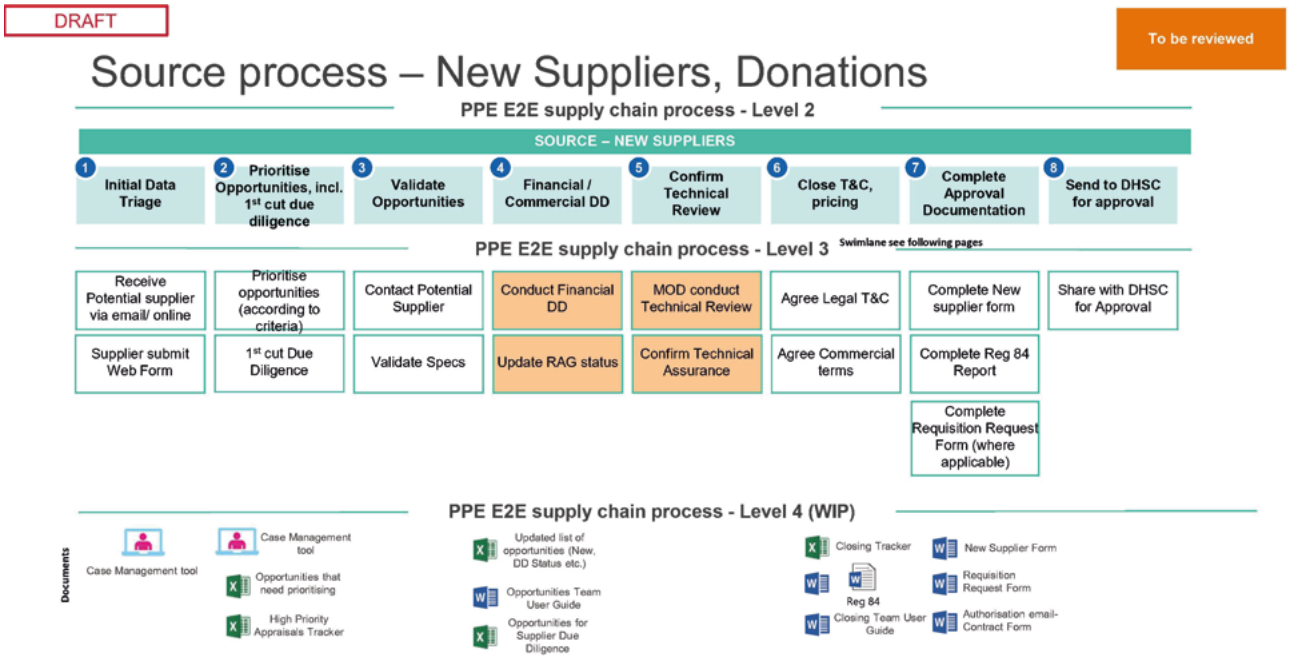
123 INQ000514103_0051 para 147
124 INQ000506052_0003
125 INQ000527570_0009 para 3.5; INQ000475379; INQ000536422_0005-0006 para 17; Tim Jarvis 12 March 2025 13/9-12
126 Darren Blackburn 6 March 2025 68/22-69/2
127 INQ000562340_0038-0039, 0055 paras 82, 127
128 James Bethell 19 March 2025 13/18-20
129 James Bethell 19 March 2025 13/17-25

2.62. Dr Jandziol and Lord Bethell highlighted the fact that the better targeted the call to arms, the more productive it was likely to be, but that the ability to issue more targeted calls was limited in the spring of 2020 as the testing technology was still emerging.[130] In the case of testing and other technical healthcare equipment, it would also have been better if the UK government had – prior to the pandemic – established useful contacts with the industry.[131]

Inefficient PPE procurement

2.63. The buying function of the PPE Cell was organised to process offers through a series of eight sequential steps, called the 'end-to-end process', each handled by separate teams of officials with each team specialising in different aspects of procurement (see Figure 6).[132] Ministers, while ultimately responsible for the system, were not involved in making decisions to award contracts.[133]

Figure 6: End-to-end PPE procurement process, Department of Health and Social Care, April 2020



Source: INQ000551580_0013

2.64. The process was established in this way because PPE needed to be purchased at such speed and scale that the operation required a large number of officials and external advisers – many not experienced in the procurement of healthcare

130 Beverley Jandziol 13 March 2025 138/8-140/11; James Bethell 19 March 2025 14/10-15/2
131 Beverley Jandziol 13 March 2025 140/14-141/16
132 INQ000528391_0120-0137 paras 444-500
133 INQ000528391_0005 para 14

equipment – to work together. By 23 June 2020, the PPE Cell comprised approximately 611 officials, 34 consultants and 148 external advisers.[134]

2.65. The task needed to be segmented into smaller elements and each discrete task taught to the newly created specialist teams.[135] The process had the benefit of getting a large and brand new team started quickly on emergency procurement.

2.66. However, it was inefficient, for three principal reasons:

- There was a lack of integration and coordination between procurement teams.
- The system was unduly complex.
- The process was overly bureaucratic and labour-intensive.[136]

Lack of integration and coordination between procurement teams

2.67. The New Buy, China Buy and UK Make teams each pursued different and sometimes competing strategies for purchasing PPE. For example:

- The China Buy team purchased from manufacturers and distributors at or closer to the source of production. The New Buy team generally purchased from intermediaries further down the supply chain. As a result, the China Buy and New Buy teams were sometimes in direct competition with each other, causing increases in price.[137]
- As purchases generally had first to be approved by the Department of Health and Social Care, officials in China, usually working for the Foreign and Commonwealth Office, had to wait for officials in the UK for approval before purchasing vital healthcare equipment. As a result, the UK's buying operation was "*consistently behind the curve*" and lost offers to countries competing for the same healthcare equipment.[138]
- As the three teams, along with Supply Chain Coordination Ltd, sought independently to buy as much PPE as they could, and there was no adequate system to coordinate their efforts, the risk increased that the Department of Health and Social Care would overbuy PPE, wasting money.[139]
- Joint teams established during the pandemic by the Department of Health and Social Care, the Foreign and Commonwealth Office and the Department for International Trade for the international procurement effort were "*evolving constantly*".[140] As a consequence, there was an absence of defined, clear and

134 INQ000528389_0021-0022 para 2.58
135 Chris Hall 6 March 2025 116/22-117/4
136 INQ000551580_0014, 0016-0017, 0020, 0023-0024, 0028-0030
137 Andy Wood 6 March 2025 180/14-20, 181/11-22; Simon Manley 10 March 2025 103/17-105/5; INQ000494034_0001-0003; INQ000534713
138 INQ000493785_0002
139 INQ000528391_0087 para 324
140 Simon Manley 10 March 2025 109/5-15

fixed lines of responsibility between the three departments.[141] As Simon Manley, later Sir Simon Manley (Director General, Covid-19 at the Foreign and Commonwealth Office from March to September 2020), told the Inquiry, if the trade and investment expertise of the Department for International Trade had been available at an earlier stage, better procurement processes might have been established sooner.[142]

2.68. Many of these challenges would have been minimised if the Department of Health and Social Care had ensured that procurement teams had an effective means of sharing up-to-date data or a "*single point of information*", including about reliable suppliers, offers, decisions to procure and delivery schedules.[143] However, this was absent at the start of the pandemic.[144] The system was not sufficiently integrated or coordinated.

Unduly complex system for processing offers

2.69. Although in the absence of any plan to establish an emergency procurement system officials may have done the best they could in the circumstances, the end-to-end process created by the Department of Health and Social Care was unduly complex. The next stage of the procurement process could not be reached until the preceding stage had been satisfactorily completed; it was rightly described as "*very linear*".[145] The Inquiry was told that the need for a handover at each stage made it "*very slow*" and "*cumbersome*" and led to "*inefficiencies*".[146] Even good offers took weeks to process.[147] When applied to international procurement with officials located in the UK and overseas, as with the China Buy team, the complexity created "*delay*", "*frustration*" and "*constant tension*".[148]

2.70. Jonathan Marron, Director General at the Department of Health and Social Care from June 2017 to July 2025, maintained that, as procurement was itself a complicated task, the process was not unduly complex.[149] Others disagreed – their experience engaging with the system was a source of tension and slowed down procurement.[150]

2.71. A 'complicated' task does not necessarily require a complex process. In the volatile, competitive market of the pandemic, where speed and responsiveness were of the essence, the system did not adequately meet the challenge. A parallel process in which multiple stages for an offer could be completed simultaneously – combined with procurement teams organised by category of healthcare equipment – would

141 Simon Manley 10 March 2025 109/5-15
142 Simon Manley 10 March 2025 109/16-25
143 Simon Manley 10 March 2025 105/12
144 Simon Manley 10 March 2025 105/7-16; Andy Wood 6 March 2025 180/21-181/22
145 Gareth Rhys Williams 4 March 2025 192/9-11; INQ000551580_0014-0017; Jonathan Marron 5 March 2025 147/22-150/4
146 INQ000536422_0022 para 67; Max Cairnduff 6 March 2025 23/22-23; Gareth Rhys Williams 4 March 2025 193/5-9
147 INQ000536422_0022 para 67; Gareth Rhys Williams 4 March 2025 193/5-9
148 INQ000477701; INQ000493785; Simon Manley 10 March 2025 96/17-97/6, 99/25
149 Jonathan Marron 5 March 2025 150/2-4; Gareth Rhys Williams 4 March 2025 193/10-14
150 Paul Deighton 18 March 2025 67/9-68/9, 74/24-75/1, 75/11-76/2; INQ000534603_0030; INQ000539153_0096; Darren Blackburn 6 March 2025 84/20-85/7; Simon Manley 10 March 2025 98/19-100/1; INQ000477701

likely have been a better approach (see Chapter 4: Global supply chains and domestic industrial resilience). Although changes were made and, in July 2020, the PPE Cell was reorganised into teams focused on the categories of PPE being procured, by this time the most acute phase of the procurement emergency was over.[151]

Overly bureaucratic and labour-intensive

2.72. The end-to-end process required eight separate groups of officials to assess and process offers comprising large quantities of documents, ranging from due diligence and technical specifications to invoices and contracts.[152] Large quantities of procurement information were frequently transferred between suppliers and officials and between groups of officials, using several forms and multiple email inboxes as a means of collecting, organising and analysing the information.[153] Darren Blackburn (Deputy Director in the Government Commercial Function Complex Transactions Team at the Cabinet Office from September 2019 to May 2022 and Head of New Supplier Sourcing in the PPE Cell from April to July 2020) described the key issues as finding and processing credible offers quickly and how the system, as it was set up, made both difficult.[154]

2.73. Although the establishment of the PPE Cell resulted in a transformation in the UK government's procurement and distribution operation, the PPE procurement structures, systems and processes were designed in the middle of the crisis and suffered as a consequence.[155] As Chris Hall (Deputy Director, Cabinet Office Complex Transactions Team and a manager in the PPE Buy Cell from April to June 2020) put it in an email in April 2020, officials had "*designed the least efficient process possible*".[156] To their credit, the procurement systems were developed and improved during the pandemic by:

- relying on better information technology to collect and analyse procurement data;[157]
- establishing a rapid review team to speed up the processing of good offers through the system;[158] and
- moving to a process in which specialist teams focused on procuring specific categories of PPE.[159]

2.74. This final improvement by the Department of Health and Social Care was crucial, but it came in July 2020, by which time it was too late. In July 2020, the PPE Cell

151 INQ000528391_0005-0006, 0190-0191 paras 17, 724-725
152 Jonathan Marron 5 March 2025 150/5-163/18; INQ000474996
153 INQ000474996
154 Darren Blackburn 6 March 2025 67/14-68/14
155 Jonathan Marron 5 March 2025 164/8-25
156 INQ000527547_0001; Chris Hall 6 March 2025 116/9-20
157 Jonathan Marron 5 March 2025 154/6-22
158 Jonathan Marron 5 March 2025 156/25-157/12
159 Jonathan Marron 5 March 2025 157/19-25

transitioned from a process model to a more effective category model in which specialist teams focused on procuring a particular type of equipment, a practice standard in the private sector.[160] This new model, tested and proven effective in UK Make by Paul Deighton, Lord Deighton, who led the UK government's procurement of PPE from April to July 2020 (see Chapter 4: Global supply chains and domestic industrial resilience), provided several advantages. These included:

- being able to see a whole supply chain;
- focusing responsibility in a single team;
- providing more control over the process; and
- enabling purchases to be better aligned with demand.[161]

2.75. Many of the difficulties arose from the fact that the PPE Cell was an emergency response attached to a system that was unable to grow quickly enough to respond to the emergency.[162] Key to future preparedness and resilience in procurement are the ability to build on an already effective procurement system, access to better inventory data, a better system of triage and earlier, collaborative relationships with key manufacturers.[163]

2.76. The system during the pandemic was overly bureaucratic and labour-intensive (see Chapter 7: Data, technology and the future of emergency procurement).

Capacity to distribute to the social care sector

2.77. As set out in Chapter 1: The UK's readiness for emergency procurement and distribution, it was not anticipated by the UK government or the devolved administrations that they would need to extend the procurement and distribution of PPE to the care sector. PPE was eventually made available free of charge across all four nations during the pandemic, but this was not the starting point.[164]

2.78. The logistics and distribution operation was complicated. Sir Nicholas Carter, then Chief of the Defence Staff, described the distribution of PPE during the pandemic as "*the single greatest logistical challenge*" he had encountered.[165]

2.79. The first challenge was to expand the PPE delivery operation from the hospital and secondary care sector to encompass the care sector. In England, this meant an enormous expansion. The number of settings to which deliveries would need to be

160 INQ000536422_0005-0006 paras 16-17
161 Paul Deighton 18 March 2025 67/9-17; Jonathan Marron 5 March 2025 157/13-25; INQ000536422_0005-0006 para 17
162 Jonathan Marron 5 March 2025 167/5-8
163 Jonathan Marron 5 March 2025 167/15-21, 168/5-14, 169/1-8, 170/8-24
164 INQ000536418_0020-0021 paras 89-90; INQ000521969_0025-0026 paras 94-95; INQ000535015_0014-0015 para 48; INQ000103717_0004-0008
165 INQ000528391_0006 para 19

made in England grew from 226 NHS trusts to approximately 58,000 destinations, each with different PPE requirements.[166]

2.80. In Scotland, Paul Cackette, Director of the PPE Directorate in the Scottish Government from April to June 2020, described this as his "*single biggest and most difficult challenge*".[167] National Procurement's role expanded on 13 March 2020 to include social care, with pandemic stocks serving as a "*stock of last resort*" for the sector from 17 March.[168] A one-off top-up supply was also announced on 17 April 2020 by Jeane Freeman MSP (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021).[169]

2.81. The remit of NHS Wales Shared Services Partnership was widened to supply to the social care sector on 19 March 2020.[170] The Welsh Government included the social care sector in NHS Wales Shared Services Partnership's distribution and ensured that PPE was made available free of charge until 2023.[171]

2.82. In Northern Ireland, where health and social care were already more integrated, the Business Services Organisation's Procurement and Logistics Service already held responsibility for procurement for social care and did so throughout the pandemic, although not for social care provided by the independent sector.[172] There was no existing system for distribution to the social care sector on this scale. The Department of Health (Northern Ireland) accepted that there were issues with access to PPE on the ground due to problems with "*distribution and logistics*", as the "*business-as-usual system could not cope with the demands being placed on it at that point*".[173]

2.83. The use of large, locally based distribution points for onward distribution to individual care homes formed a key part of the logistics operation across the UK. However, these distribution points lacked the ability to track what was being distributed onwards, where it was going and how quickly stock was being used. This meant that care homes did not always know how much stock was available and when it might arrive. In an attempt to deal with this, in Scotland, a call centre and 48 regional PPE hubs were rapidly established. These hubs, supplied by NHS National Services Scotland with distribution from the National Distribution Centre (the central hub for distributing key medical equipment and supplies), allowed the social care sector free access to PPE.[174] In Wales, PPE was distributed to the social care sector through a network of local authority Joint Equipment Stores (a network of stores of mobility equipment and other equipment used by local authorities to deliver basic services in non-pandemic times, but also used to distribute PPE during the pandemic).

166 INQ000492085_0057; INQ000528391 _0006, 0247 paras 19, 928
167 INQ000512904_0026 para 3.62
168 INQ000521969_0025 para 94
169 INQ000498141_0033 para 91
170 INQ000506956_0042 para 177
171 INQ000527571_0019-0021 paras 65, 68-70; INQ000506956_0068-0074 paras 288-320
172 INQ000514103_0008-0009 para 17
173 Christopher Matthews 26 March 2025 81/1-24
174 INQ000498141_0032 para 89

2.84. Inventory management at local distribution hubs was a struggle in Wales and Scotland. There were instances in the spring of 2020 in which hubs in Scotland lacked the resources, infrastructure and processes to manage the emergency distribution of PPE, becoming overwhelmed and leading to delays in distribution.[175] The Welsh Local Government Association told the Inquiry that PPE distribution improved after April 2020.[176] However, the Army had been asked to assist and its assessment of the situation in April 2020 was that the social care sector was buying significant amounts of PPE from the private market and would not have enough for its staff if it switched to relying entirely on supplies from NHS Wales Shared Services Partnership.[177] More fundamental issues were identified across the rest of the PPE distribution network in Wales, which highlighted a lack of modern inventory systems in hospitals across the NHS in Wales and in turn the absence of a real-time, modern demand signalling tool to assist NHS Wales Shared Services Partnership. The need for such tools should have been anticipated as necessary for an efficient pandemic distribution operation and would have become apparent through distribution stress-testing, had this been carried out. As the PPE distribution operation began in Wales, several issues arose, including:

- There was no clear picture on usage rates.[178]
- There would only be two to four weeks of supply remaining if current usage rates continued.[179]
- There was no clear understanding at a local level of when stocks would be replenished from the central supply once used.[180]

2.85. The introduction of an electronic data system in September 2020 across the Joint Equipment Stores in Wales improved PPE allocation to the social care sector, as it allocated PPE based on demand rather than estimates.[181]

2.86. There was a different challenge in Northern Ireland. The Department of Health (Northern Ireland) told the Inquiry that there was some tension between trusts and independent care providers, with trusts making only limited supplies of PPE available to the independent sector and at least one trust reporting that parts of the social care sector were using unusually high levels of PPE.[182]

2.87. A Northern Ireland Audit Office report published in March 2022 recommended that long-term arrangements for the supply of PPE to independent healthcare

175 INQ000320479_0002; INQ000512904_0028 paras 3.71-3.73
176 INQ000518355_0014 para 29
177 INQ000470703_0004 para 3a
178 INQ000299126_0003-0004 para 11
179 INQ000299126_0001-0002 para 3
180 INQ000299126_0003-0004 para 11
181 INQ000521963_0008 para 34
182 INQ000521964_0097 para 321

providers needed to be clarified.[183] Although the Business Services Organisation's Procurement and Logistics Service and the Department of Health (Northern Ireland) both accepted the findings, it is still not clear what arrangements would apply to the supply of PPE to the independent healthcare sector in the event of a future pandemic.[184]

2.88. The experience of all four nations shows that long-term planning for emergency distribution to the care sector is needed across the UK. This will be considered by the Inquiry in Module 6: Care sector.

Poor integration of procurement and distribution

2.89. Getting the right volumes of equipment to the right places at the right times needed regular calibration of procurement decisions with delivery schedules, logistics and distribution capacity, and usage rates. With PPE arriving from international and domestic manufacturers facing disruption and delays caused by breakdowns in supply chains (see Chapter 4: Global supply chains and domestic industrial resilience), it was a difficult task to balance demand with supply.

2.90. Between March and May 2020, decisions by the UK government about the types, quantities and cost of equipment were informed by analysis from external advisers such as McKinsey and Efficio. They provided modelling expertise to the Department of Health and Social Care but, because accurate data were scarce, leading modellers had to rely on estimates for usage rates and demand.[185]

2.91. There were no modern, accurate inventory management systems in place at trust level that recorded usage rates. Dame Emily Lawson considered that, for reasons of proportionality (which would include resources), there was no consensus for such systems in England.[186] Although some trusts did have electronic inventory systems, most did not and, until the introduction of a more advanced system in England in late April 2020, they generally relied on completing spreadsheets and estimated usage rates to feed data back to the PPE Cell (see Chapter 7: Data, technology and the future of emergency procurement).[187] External advisers developed targets for PPE based on sporadic usage rates reported by the health and social care sectors, but their predictions were necessarily made on the basis of incomplete data and assumptions that were subject to change, including estimated PPE arrival dates, contract performance and guidance on the use of PPE issued to health and social care workers.[188] In the absence of reliable usage rates and with uncertainty about the

183 *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers*, Northern Ireland Audit Office, 1 March 2022, pp17, 66-67, paras 20, 6.11, 6.13 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882)
184 INQ000514103_0073-0074 para 225; Karen Bailey 26 March 2025 43/9-45/6
185 INQ000497031_0151-0155 paras 4.322-4.340
186 INQ000572261_0047 para 199
187 INQ000572261_0036 para 153(d)
188 INQ000497031_0153–0155 paras 4.332-4.339

contractual performance of PPE suppliers, modellers erred on the side of caution and produced significant overestimates of need.[189] Until May 2020, there were insufficient data available to model buying targets.[190]

2.92. Although keeping track of stock movements from manufacturers to warehouses and end-users in hospitals and social care settings was essential for establishing a reliable picture of incoming supplies, procurement officials in the PPE Cell did not generally keep records of delivery schedules at the time of purchase. In about March and April 2020, those involved in distribution – including the Ministry of Defence's logistics team, the Army and various logistics companies – had to undertake the significant challenge of chasing for delivery information.[191]

2.93. The majority of the PPE Cell's shipping arrangements were managed by Uniserve, a supply chain and logistics company, which operated OneWorld, a specialist IT system to track the progress of shipments.[192] This system only became available in May 2020 – prior to this, the PPE Cell could not track when bought stock would be arriving in the UK.[193] OneWorld relied on the quality of the data provided to it and, as the PPE Cell had "*poor data*", it "*could not get the best out of the system*".[194] The process of transferring data to OneWorld brought to light a number of issues with the existing systems in use by the PPE Cell, including that products arriving in the UK came without a product description, making it difficult to match up contracts with items, and the warehouse being "*spreadsheet driven*", relying on manual entry with "*multiple systems*" that were "*not connected*".[195] As Major General Prosser told the Inquiry, "*the logistics information systems were not well integrated or modernised*".[196] There was a lack of visibility about what was being demanded, supplied and in transit.[197]

2.94. Between March and May 2020, officials continued to buy PPE either not knowing about its delivery or not being able to track it. This made it difficult to balance supply and demand.[198] In an email to Sir Gareth Rhys Williams in April 2020, Mr Hall stated that the system was "*fundamentally broken*" and that "*lag in the process and shipping is killing our demand signal*".[199] By June 2020, it was clear from modelling that the PPE Cell was on course to procure significantly more PPE than was required.[200] This is discussed in Chapter 7: Data, technology and the future of emergency procurement.

189 INQ000506021; INQ000536362_0014 para 37
190 INQ000497031_0153 para 4.334
191 INQ000498259
192 INQ000536421_0011 para 38
193 INQ000477714_0049-0050
194 INQ000562459_0034-0035 paras 150-151
195 INQ000562459_0030 para 128
196 INQ000560895_0025 para 80
197 Phillip Prosser 26 March 2025 160/5-20
198 Phillip Prosser 26 March 2025 155/18-157/8
199 INQ000527547_0001; Chris Hall 6 March 2025 116/9-20
200 INQ000528391_0190-0191 paras 721-725; INQ000536369_0049 para 12.3. Statistical models are tools for analysing complex data, identifying patterns, and informing evidence-based decision-making where direct measurement is not possible. Figures from modelling are estimates only, and different statistical models will produce different outcomes. These estimates are not based on direct observations. They are therefore limited by the underlying assumptions used in the models and are subject to uncertainty.

2.95. The ability to plan distribution effectively was hindered by the PPE Cell not being organised around a single, central digital system that matched up data on what was being demanded by the health and social care sectors, procured by the PPE Cell and delivered to Daventry.[201] Instead, it was decided in daily meetings of officials at which the various sets of data were considered manually.[202] The existing systems were outdated and each party involved in distribution, whether from the public or private sector, had their own software platforms which were not connected with those used by procurement officials.[203] The situation only improved with the introduction of Foundry, a national data system introduced by NHS England in late April 2020.[204]

2.96. As PPE was likely to be an important resource during a pandemic, modern inventory management systems should have been put in place by the Department of Health and Social Care as part of pandemic preparedness.

Lack of coordination between governments across the UK

2.97. In the early stages of the pandemic, the devolved administrations, with smaller orders, were at a disadvantage in direct competition with the UK government, which placed larger orders with some of the same suppliers.[205]

2.98. This was complicated by what was perceived as poor communication by the UK government with the devolved administrations. This generated mistrust.[206] For example, in April 2020, the UK government informed the devolved administrations that UK embassies had been instructed to work on a single request on behalf of the UK as opposed to the devolved administrations individually, as this was "*the best way to obtain a supply of goods that can support the needs of the whole of the UK*".[207] Ms Freeman and Ms Lamb considered that, as procurement of healthcare equipment was a devolved matter, it was not for the UK government to decide on a UK-wide response.[208] The Inquiry understands their concern. However, it was the UK government that, in the extremely competitive global market for healthcare equipment during the pandemic, had both the purchasing power and the connections overseas and was best placed to source equipment (see Chapter 4: Global supply chains and domestic industrial resilience).

2.99. Between 31 January 2020 and 12 March 2020, officials from the devolved administrations met with officials from the Department of Health and Social Care, Public Health England and Supply Chain Coordination Ltd daily.[209] There were then regular meetings between ministers and officials from the UK government and

201 INQ000528391_0175-0176 paras 663-667
202 INQ000528391_0175-0176 paras 663-667
203 Phillip Prosser 26 March 2025 161/4-22; INQ000553497_0007, 0017-0018 paras 18, 46; INQ000562338_0016 para 41.7; INQ000531295_0014, 0016 paras 56, 59d
204 INQ000528391_0202 para 758; INQ000528295_0006, 0010, 0011
205 INQ000536485_0023 para 68; INQ000513733
206 INQ000513729
207 INQ000496582_0001
208 INQ000498141_0070 para 234
209 INQ000528391_0179 para 678

devolved administrations to discuss the emergency procurement and distribution of PPE across the UK.[210]

2.100. Despite this regular contact, Ms Lamb believed that there were also challenges in 2020 with accessing sufficient data about the UK government's stocks of PPE, which initially impacted Scotland's PPE procurement decisions.[211] In Wales, Andrew Slade (Director General, Economy, Skills and Natural Resources in the Welsh Government from January 2018 to April 2022 and Director General, Economy, Treasury and Constitution from April 2022 to March 2024) told the Inquiry that arrangements in England appeared to be "*very fragmented*" and there was "*no assurance on how and when they would supply PPE to the four nations to replenish stock*".[212] In Northern Ireland, Tim Losty (Director of International Relations in The Executive Office from 2012 to 2021) told the Inquiry that, at times, the UK government:

> "*came across as disinterested in working with, or hearing the concerns of the Devolved Administrations and this was sometimes reflected in the attitudes of some UK officials*".[213]

Although sharing of PPE between the four nations improved as the pandemic progressed, the devolved administrations procured the majority of their own.[214] At times, one nation effectively led contract negotiations and shared equipment under mutual aid arrangements for the transfer of PPE between the four nations to meet emergency shortages, but this cooperation was ad hoc.[215]

2.101. In future, a better, more coordinated procurement and sharing strategy should be adopted across the UK. This would enable the UK government and devolved administrations to avoid competing for equipment and to coordinate their collective purchasing power. The aim should be to ensure value for money and that health and social care workers throughout the UK have adequate equipment. Clear, established arrangements between the UK government and devolved administrations will help to avoid poor coordination and confusion in a future emergency.

New emergency procurement and distribution systems

2.102. The absence of adequate – and adequately prepared – systems in the UK for procurement and distribution of key healthcare equipment and supplies in an

210 INQ000528391_0179-0185 paras 679-702
211 INQ000498141_0070-0071 para 235
212 INQ000506956_0040 para 166
213 INQ000541535_0027 para 106
214 INQ000498141_0068 para 224; *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers*, Northern Ireland Audit Office, 1 March 2022, pp44-45 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882); INQ000536485_0042 para 142
215 INQ000528391_0179-0185 paras 677-703

emergency, such as the Covid-19 pandemic, meant that new structures and processes had to be created at speed and under immense pressure.

2.103. The major weaknesses in the new systems, created as they were amid the crisis, were caused principally by: the lack of an effective system to triage offers, overly complex and bureaucratic processes, and poor integration and coordination between procurement teams and between procurement and distribution teams. This resulted in inefficiency, bottlenecks and a lack of visibility throughout the system. The risk to those on the front line of the health and social care sectors was only too real. The absence of adequate planning for – and response to – the needs of the social care sector left some of the most vulnerable exposed.

2.104. The challenges in the rapid, large-scale procurement and delivery of critical supplies demonstrate an urgent need to overhaul emergency structures and processes ahead of a future pandemic. The systems established during the pandemic proved to be too slow, too uncoordinated and too resource-intensive to manage procurement and distribution effectively in a crisis. Future preparedness depends on a resilient and adaptable national infrastructure that is integrated, can rapidly and efficiently scale up operations, uses market research, modelling and price benchmarking to ensure value for money, and allows scope for innovative developments in healthcare equipment.

Recommendation 3: Emergency procurement and distribution systems for the UK

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive, within 12 months of the publication of this Report, should each have ready systems for the emergency procurement and distribution of healthcare equipment.

These new systems must:

- integrate procurement and distribution;
- have the ability rapidly to scale up efficient operations, including through integrated emergency procurement teams and automating the triaging and processing of offers of supply; and
- be able to use market research, modelling and price benchmarking to ensure value for money.

Chapter 3: Regulation, inspection and enforcement

Introduction

3.1. The safety of healthcare equipment for health and social care workers is of central importance to the procurement process. The systems of regulation, inspection and testing of healthcare equipment are designed to ensure that end-users are safe, manufacturers and suppliers understand and comply with the rules, and potentially dangerous equipment is kept out of the market.

3.2. The nature of healthcare equipment is often sophisticated. Checking compliance with regulations is difficult. Countries around the world have different regulatory standards from the UK, making the task for those considering importing equipment into the UK even more difficult. During a pandemic, the tension between speed and caution requires the regulatory sector to carry out a difficult balancing act. The Inquiry has identified examples of where regulators struck that balance well during the pandemic. However, it has also identified flaws in the system and a lack of planning in the approach to regulation adopted during the pandemic.

3.3. This chapter considers the regulation of healthcare equipment during the Covid-19 pandemic, its inspection before release onto the market and the enforcement of safety standards. It examines whether there was sufficient understanding about decisions on safety between regulators, procurement officials and end-users – such as doctors, nurses and care workers – in the health and social care sectors.

The regulation of healthcare equipment

3.4. Regulatory responsibilities in the UK and devolved administrations during the Covid-19 pandemic were and still are split between several bodies, including:

- the Medicines and Healthcare products Regulatory Agency, which ensures the safety, quality and effectiveness of medical devices and medicines;[1]
- the Health and Safety Executive and the Health and Safety Executive for Northern Ireland, which enforce the regulations relating to personal protective equipment (PPE) used in workplaces (including hospitals and care settings);[2]
- local authority trading standards teams in relation to the buying and selling of PPE;[3]
- the Office for Product Safety and Standards (part of the Department for Business and Trade), which sets policy for the safe regulation of PPE and the protection of consumers from product-related harm;[4]

1 INQ000541374_0003-0004 para 13
2 INQ000560897_0002-0004 paras 7-11
3 INQ000517443_0023 para 7.13; INQ000560897_0003 para 9; The Personal Protective Equipment (Enforcement) Regulations 2018, regulation 3(1)(a)(i) (https://www.legislation.gov.uk/uksi/2018/390/contents)
4 INQ000517443_0019-0020 paras 7.3, 7.5(a)

- the British Standards Institution, which undertakes independent assessments to determine a product's compliance with safety standards;[5] and
- Border Force and local authority trading standards teams, which have a role in seizing counterfeit goods entering or sold in the UK.[6]

A further group of 'notified' and 'approved' bodies determines whether healthcare equipment conforms with regulations.[7]

3.5. Depending on its intended use, an item of healthcare equipment might be treated either as a medical device or as PPE. In each case, different regulators would be responsible. It is possible for items to be viewed as both medical devices and PPE and, by agreement between the regulators, to change categorisation between the two. Items that might be considered healthcare equipment, such as masks, may also be used in other settings, such as construction sites.

3.6. Medical devices are items intended by the manufacturer to be used for diagnosis, monitoring and treatment or to protect patients from contamination and infection – for example, during surgery or medical treatment.[8] Ventilators and Covid-19 tests are classed as medical devices and therefore regulated only by the Medicines and Healthcare products Regulatory Agency.[9]

3.7. The term PPE is used to describe personal protective equipment used in many industries, including construction and food manufacture. From the perspective of regulations and regulators, it is equipment intended to be worn or held by a person at work which protects the wearer or user against risks to their own health or safety.[10]

3.8. As a result of the way in which the regulatory system operated, an item of PPE could fall under a different regulator, be subject to different rules and regulations and have to comply with different specifications, depending on its intended use rather than the purpose for which it was made.[11]

3.9. The system for regulating healthcare equipment during the pandemic was difficult to navigate. This was for four principal reasons:

- lack of coordination between regulators;
- complex regulations;

5 INQ000540485_0003-0004 paras 8-9
6 INQ000560897_0047 para 178
7 As of 1 January 2021, with the UK's exit from the EU, the UK introduced approved bodies, the UK equivalent of a notified body under the EU regime. The Medicines and Healthcare products Regulatory Agency is responsible for the designation and monitoring of approved bodies (see INQ000541374_0004, 0009-0011 paras 14, 33-40).
8 INQ000560897_0007-0008 paras 22-23; The Medical Devices Regulations 2002, section 2 (https://www.legislation.gov.uk/uksi/2002/618/contents)
9 INQ000541374_0004-0006 paras 17, 21
10 INQ000560897_0007 para 21; The Personal Protective Equipment at Work Regulations 1992, regulation 2(1) (https://www.legislation.gov.uk/uksi/1992/2966/contents)
11 INQ000541374_0006 paras 23-24; INQ000560897_0007-0008 paras 21-23

- a proliferation of guidance; and
- the need to balance safety and innovation.

Lack of coordination between regulators

3.10. There is no dedicated regulator for healthcare equipment in an emergency. Coordination and planning about the roles and responsibilities of the different regulators in a pandemic are, therefore, critical to ensure that they are all working together in the interests of the safety of end-users.

3.11. In early March 2020, neither the Office for Product Safety and Standards nor the Department for Business, Energy and Industrial Strategy (which oversaw it) were clear about the office's role in the regulation of PPE in a pandemic.[12] It is troubling that the Department for Business, Energy and Industrial Strategy allowed this uncertainty to persist until March 2020, instead of making the office's role clear from its inception in January 2018.[13] The Office for Product Safety and Standards had "*on more than one occasion*" stepped in as there was "*no obvious owner*" for cross-government regulatory work.[14] For example:

- Two regulators – the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency – were responsible for setting policy and regulations; with the Office for Product Safety and Standards, all three bodies were responsible for enforcement.[15]
- Four regulators were responsible for market surveillance, to ensure that products (including healthcare equipment) sold in the UK complied with safety standards. These were: the Office for Product Safety and Standards, which had overall responsibility; the Health and Safety Executive and the Health and Safety Executive for Northern Ireland (for PPE in the workplace); and the Medicines and Healthcare products Regulatory Agency for healthcare equipment categorised as a medical device.[16]

3.12. There was no pandemic plan for regulators and no pre-existing approved products list or agreed minimum technical specifications for items used to prevent the spread of a disease such as Covid-19. They had to be developed mid-crisis. The lack of pandemic planning in the regulatory sector was reflected in uncertainty about the roles of different bodies.

3.13. In recognition of the need for coordination in making decisions on whether products would meet regulatory standards, the Department of Health and Social Care set up a 'Decision Making Committee' in March 2020 to bring together as many as

12 INQ000475473
13 INQ000562460_0005 para 3.1
14 INQ000517443_0058 para 10.8; INQ000475485_0008
15 INQ000517443_0098 para 14.10(a)
16 INQ000517443_0019-0021, 0030, 0052, 0098 paras 7.3-7.5, 7.5(b), 8.19, 9.17, 14.10(a); INQ000541374_0055 para 198

12 bodies, ranging from UK government departments to regulators and public health and healthcare bodies across the UK. It was established to answer questions posed by the PPE Cell (established in March 2020 by the Department of Health and Social Care to centralise PPE procurement) as well as manufacturers and buyers of PPE and medical devices about the interpretation and application of regulations.[17] The committee considered individual products on a case-by-case basis.[18] For example, it had to assess and to reach decisions about a specific model of mask that caused respiratory issues for wearers, types of aprons (after receiving multiple queries) and a particular brand of goggles.[19]

3.14. Concerns were raised by the Health and Safety Executive and the Office for Product Safety and Standards that the Decision Making Committee was too slow in responding to technical queries.[20] A Regulatory Coordination Cell was therefore established in April 2020.[21] This cell brought together the four key regulators: the Health and Safety Executive, the Health and Safety Executive for Northern Ireland, the Office for Product Safety and Standards and the Medicines and Healthcare products Regulatory Agency.[22] It provided written guidance and advice to procurement teams within the Department of Health and Social Care, considered questions of product categorisation, conformity and assessment, and made decisions on the withdrawal of non-compliant PPE from the market in the UK and on the reuse and repurposing of PPE. It also assessed stored PPE pending its release into the health and social care systems across the UK.[23]

3.15. The Regulatory Coordination Cell was principally a discussion forum for regulators, involved fewer bodies, and, as the Office for Product Safety and Standards acknowledged, had greater authority to streamline rules and guidance.[24]
The Regulatory Coordination Cell was more effective than the Decision Making Committee and was a positive development. However, the four regulators should have had plans to establish a dedicated body, such as the Regulatory Coordination Cell, to take decisions more quickly earlier – perhaps as early as February 2020. This was when Supply Chain Coordination Ltd (the Department of Health and Social Care's central healthcare equipment procurement body) activated contracts for the emergency supply of PPE, placing its first order on 31 January 2020.[25]

17 INQ000517443_0014-0015 paras 5.2-5.4; INQ000560897_0019-0020 paras 69-70. The Decision Making Committee included representatives from the Cabinet Office, the Department of Health and Social Care, the Office for Product Safety and Standards, the Medicines and Healthcare products Regulatory Agency, the Health and Safety Executive, the Health and Safety Executive for Northern Ireland, Public Health England, NHS Improvement, NHS England, NHS Scotland, NHS Wales and the UK Infection Prevention and Control Cell.
18 INQ000560897_0033-0034 paras 121-127
19 INQ000560897_0034 paras 122-123, 126-127
20 INQ000475453_0005 para 12; INQ000478738_0001
21 INQ000517443_0015 para 5.5
22 INQ000517443_0016-0017 para 5.8
23 INQ000517443_0018-0019 para 5.14
24 INQ000517443_0099 para 14.10(d)
25 INQ000057528_0003

3.16. Although it still exists and may be convened at the request of any member, responsible minister or senior government official, the Regulatory Coordination Cell is not currently active.[26] Given the importance of regulatory expertise in ensuring that healthcare equipment reaches end-users in the health and social care sectors as quickly as possible, the cell should be convened with greater regularity to ensure that regulators have a coherent plan for a future pandemic.

Complex regulations

3.17. The regulation of healthcare equipment is set out across at least seven pieces of legislation in the UK.[27] As well as domestic legislation, other nations and international bodies (such as the European Union (EU), World Health Organization and International Organization for Standardization) adopt definitions and standards for a range of healthcare equipment available on the international market. These may be different from those applicable in the UK.[28] The rules and regulations are supplemented by written guidance which suppliers, buyers and end-users may also be required to understand.[29]

3.18. There is no single set of regulations that specifically govern the safety of items categorised as healthcare equipment, or for their use in a pandemic. Regulators, buyers, suppliers and end-users in the health and social care sectors were required to contend with a mass of rules and guidance.

3.19. The Health and Safety Executive observed that, as new information about the virus emerged, the Covid-19 pandemic presented "*a moving regulatory target*".[30] Decisions relating to the regulation of healthcare equipment had to be made on a case-by-case basis.

3.20. Two examples of the types of PPE desperately needed during the pandemic were:

- filtering facepiece respirator class 3 (FFP3) masks; and
- aprons and gowns.

26 INQ000475492_0002; INQ000659766_0001
27 INQ000560897_0006-0014 paras 20-47; The Medical Devices Regulations 2002 (https://www.legislation.gov.uk/uksi/2002/618/contents); Regulation (EU) 2016/425 of the European Parliament and of the Council (https://www.legislation.gov.uk/eur/2016/425/contents); The Personal Protective Equipment at Work Regulations 1992 (https://www.legislation.gov.uk/uksi/1992/2966/contents); The Personal Protective Equipment (Enforcement) Regulations 2018 (https://www.legislation.gov.uk/uksi/2018/390/contents); The Control of Substances Hazardous to Health Regulations 2002 (supplemented by an Approved Code of Practice and guidance) (https://www.legislation.gov.uk/uksi/2002/2677/contents); Regulation (EC) No 765/2008 of the European Parliament and of the Council (https://www.legislation.gov.uk/eur/2008/765); The Management of Health and Safety at Work Regulations 1999 (https://www.legislation.gov.uk/uksi/1999/3242/contents)
28 INQ000560897_0008, 0018-0019, 0040 paras 25, 64-67, 154; INQ000541374_0035 para 123
29 INQ000560897_0017, 0029-0030 paras 59, 103-104; INQ000539148_0010-0011 paras 38, 40
30 INQ000269707_0002 para 1.2

FFP3 masks

3.21. As examined by the Inquiry in its Module 3 Report, FFP3 masks were an essential piece of equipment in the health sector during the pandemic.[31] For an item to be properly described as an FFP3 mask, it must have a 99% filtering efficiency.[32]

Figure 7: A standard FFP3 mask

Source: INQ000474282_0028 Figure 6

3.22. The regulations do not differentiate between whether microscopic particles (against which masks are intended to protect) originate from construction dust on a building site, flour dust in a bakery or fluids in a hospital.[33] Obviously, it was not necessary to consider whether an FFP3 mask that was used as healthcare equipment in a pandemic offered adequate protection from brick or flour dust. However, the regulations do not allow for different technical standards to apply for PPE used in different settings, for example masks in hospitals as opposed to bakeries or building sites.[34]

3.23. Generally, if an item is designed to protect the wearer, such as a health and social care worker, it may be classified as PPE (and regulated principally by one set of regulations under the remit of the Health and Safety Executive). If it is designed to protect others, such as a patient, it may instead be classified as a medical device (and regulated principally by another set of regulations under the remit of the Medicines and Healthcare products Regulatory Agency). Some items may be considered 'dual purpose' – protecting both the wearer and others – and potentially have to comply with both sets of regulations and fall under the remits of both regulators.[35]

31 *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
32 INQ000529794_0003
33 INQ000489562; Regulation (EU) 2017/745 of the European Parliament and of the Council (https://www.legislation.gov.uk/eur/2017/745/contents); Council Directive 89/686/EEC of 21 December 1989 on the approximation of the laws of the Member States relating to personal protective equipment (https://eur-lex.europa.eu/eli/dir/1989/686/oj/eng); Graham Russell 12 March 2025 62/24-66/17, 85/10-86/11
34 Graham Russell 12 March 2025 63/8-66/2
35 INQ000560897_0008 para 23

3.24. The regulations and remit of the regulator could change depending on the protection provided by an item in connection with a particular use. For example, one brand of mask gained approval as a medical device (and therefore fell under the remit of the Medicines and Healthcare products Regulatory Agency), but it could also have been categorised as PPE and have fallen under the remit of the Health and Safety Executive due to the splash protection it offered to the wearer when used in certain circumstances.[36]

3.25. Graham Russell, Director within the Competition, Markets and Regulatory Reform division of the Department for Business, Energy and Industrial Strategy as Chief Executive of the Office for Product Safety and Standards from 2018, explained that the question was where the boundaries were drawn in regulation for equipment that may have multiple uses.[37] However, the regulations lacked a focus on how items would be used in practice, in an emergency and in the more limited context of health and social care settings.

3.26. It should not be necessary in an emergency for regulators, manufacturers and suppliers to have to consider all potential uses for an item and compliance with further detailed regulations in order to bring vitally needed equipment onto the market.

Aprons and gowns

3.27. The regulation of aprons and gowns (which should have been straightforward) provides another example of the problems created by regulatory complexity.

3.28. Aprons are suitable for some clinical environments and gowns for others.[38] A disposable apron was considered appropriate for contact with patients with a possible or confirmed Covid-19 infection, whereas the greater protection offered by a long-sleeved fluid-repellent gown was appropriate for aerosol generating procedures (medical procedures which may cause the production of infectious particles and increase the risk of transmission of a respiratory virus).[39]

36 INQ000560897_0024 para 87
37 Graham Russell 12 March 2025 63/15-24
38 INQ000574647_0013; INQ000529556; INQ000529264_0003
39 INQ000529545

Figure 8: Photographs of an apron (top) and a gown (bottom)

Source: INQ000529545_0001 Figures 1 and 3

3.29. Just as with FFP3 masks, if an apron or gown is worn in a clinical environment to protect the patient, it could be categorised as a medical device and fall under the remit of the Medicines and Healthcare products Regulatory Agency. However, if it is worn to protect the wearer, it could instead be categorised as PPE and fall under the remit of the Health and Safety Executive.[40] During the pandemic, there was an added layer of complexity in the case of aprons and gowns arising from the effect of guidance based on the circumstances in which they should be worn.

3.30. As examined in Module 3, the UK Infection Prevention and Control Cell was a body which evolved informally from NHS England's Infection Prevention and Control team in February 2020. It advised on the content of guidance issued by the Department of Health and Social Care and the public health agencies during the pandemic on the use of PPE to prevent the spread of infection. The guidance issued by the UK Infection Prevention and Control Cell was capable of changing the circumstances in which PPE should be worn and therefore the regulations and regulator under which it fell.[41]

40 INQ000541374_0006, 0045, 0062-0063 paras 23, 164, 227

41 *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapters 1 and 2 (https://covid19.public-inquiry.uk/documents/module-3-full-report)

3.31. In June 2020, the UK Infection Prevention and Control Cell changed its guidance to allow the use of over-the-head, plastic disposable aprons as an alternative to fluid-repellent gowns to protect health and social care workers but also, in some settings, to protect vulnerable or shielding patients.[42] This triggered discussion among the regulators as to how aprons and gowns should be categorised under the regulations.[43] There was no immediate answer to the problem.

3.32. The regulations were so complex that, in an attempt to navigate the issue, the Health and Safety Executive produced an eight-page discussion paper entitled 'Aprons are they PPE?'.[44] In May 2020, the Decision Making Committee decided to categorise aprons as medical devices.[45] However, in August 2020, the Health and Safety Executive and the Office for Product Safety and Standards then agreed that both aprons and gowns should instead be classified as PPE.[46]

3.33. As a result of the uncertainty, manufacturers did not initially know which specifications they should use to produce the critical equipment that was needed.[47] The shifting ground of categorisation also meant that buyers and end-users of aprons and gowns were operating in the dark.

3.34. The regulations were difficult for the responsible regulators to navigate. The intended use of an item of healthcare equipment plays a crucial role in the regulations for determining its classification as PPE or a medical device (or both), as well as under which sets of regulations and under which regulator's remit it falls.[48] However, this approach to regulation does not focus on the practicalities of how healthcare equipment will be used in a pandemic.

Experiences of suppliers, buyers and end-users

3.35. Suppliers, buyers and end-users of healthcare equipment in the health and social care sectors need to be able to understand, interpret and apply the regulations to ensure that items are safe.

3.36. As the regulations were so complex, some suppliers had to be guided through the regulatory process. The top 10 new large-scale manufacturers of PPE (as identified on behalf of the Cabinet Office) were given tailored assistance by officials in the Office for Product Safety and Standards (discussed in Chapter 4: Global supply chains and domestic industrial resilience).[49] However, even these officials found the regulations difficult to navigate and this slowed down the supply of PPE.[50]

42 INQ000529556; INQ000529545_0002-0006
43 INQ000560897_0022-0023 paras 81-82; INQ000529545; see also INQ000269707_0010 para 5.1.8; INQ000528391_0004 para 10; INQ000541374_0006 para 24
44 INQ000529545
45 INQ000560897_0022-0023 para 81
46 INQ000560897_0022-0023 para 81
47 INQ000529264_0003
48 INQ000560897_0007-0008 paras 21-23; INQ000529220_0011-0017; INQ000529425_0021-0028
49 INQ000517443_0024-0025 paras 7.21-7.22; INQ000536422_0026-0027 para 83; Paul Deighton 18 March 2025 84/10-86/4
50 Paul Deighton 18 March 2025 75/15-18, 81/17-21, 84/10-25, 86/17-88/5

Paul Deighton, Lord Deighton (who led the UK government's procurement of PPE from April to July 2020), explained to the Inquiry that it was "*very difficult for a system based on safety to respond to a crisis at pace*".[51] The regulations were not designed with the kind of speed and simplicity needed for a pandemic.

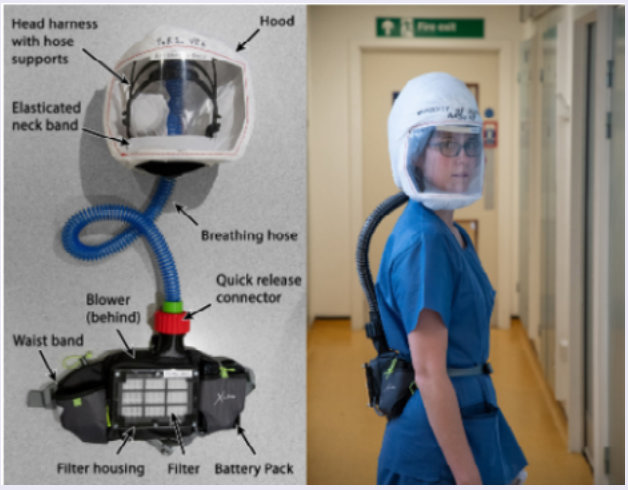
3.37. Government help to get suppliers through the regulatory process was not available to all.[52] Other new and innovative entrants to the market – such as the inventors of an alternative to FFP3 masks called 'PeRSo hoods' – did not have the benefit of this kind of direct government assistance. They struggled with the regulations.

Case study: PeRSo hoods

On 16 March 2020, Professor Paul Elkington (Professor of Respiratory Medicine at the University of Southampton) contacted Professor Hywel Morgan (Professor of Bioelectronics at University Hospital Southampton) to develop an alternative to FFP3 masks that would not require fit-testing and would be reusable.

In partnership with local businesses, they developed the PeRSo hood – a battery-powered respirator hood with a built-in air filter. Within a week, a prototype had been built which passed initial testing, and by 23 March the hood was being piloted by doctors and nurses with "*overwhelmingly positive*" feedback.[53]

Figure 9: PeRSo hood



Source: 'A personal respirator to improve protection for healthcare workers treating COVID-19 (PeRSo)', PT Elkington, AS Dickinson, MN Mavrogordato, DC Spencer, RJ Gillams, A De Grazia et al, Frontiers in Medical Technology, 2021, 10(3), Figure 2 (https://pubmed.ncbi.nlm.nih.gov/35047921; INQ000474768_0004)

51 INQ000536422_0026-0027 para 83
52 INQ000513191_0009 para 37; INQ000234522_0030 para 5.17; INQ000475453_0006-0007, 0011, 00146 para 20, Annex 3 para 11
53 INQ000581862_0001 para 1

Although respirator hoods were already recognised as an acceptable alternative to FFP3 masks, the process for obtaining regulatory approval was "*extremely opaque*".[54]

In the summer of 2020, the British Standards Institution granted permission for the PeRSo hood to be used as an alternative to FFP3 masks, but there were then several months of delay due to a lack of capacity within testing bodies.[55] Further delays were caused by issues with the PeRSo instruction manual, difficulties in providing the required testing documentation for regulators, and the slow decision-making of regulators, who waited for each other to make decisions about compliance.[56]

Unlike some domestic manufacturers of PPE (such as those in the UK Make programme – see Chapter 4: Global supply chains and domestic industrial resilience), the developers of the PeRSo hood did not benefit from tailored assistance to guide them through the regulatory and procurement processes.[57]

Regulatory approval was eventually granted and the PeRSo hood was subsequently sold to local NHS trusts, with more than 1,500 PeRSos being used in Southampton during the first wave of the pandemic and a further 3,500 during the second wave.[58]

3.38. As with manufacturers and suppliers, buyers of PPE also had to understand and navigate the regulations to ensure that the equipment they were buying for health and social care workers was safe.

3.39. Andy Wood (Deputy Director, Commercial Specialist in the Cabinet Office and Lead for the PPE Buy Cell, a sub-set of the PPE Cell, from March to July 2020) told the Inquiry that the PPE Cell had "*little or no experience*" in buying PPE.[59] It therefore initially relied on a small number of qualified staff from Supply Chain Coordination Ltd "*to guide and train*" the team in the items that needed to be bought, the technical standards that needed to be met, the packaging and labelling requirements and the required testing of the equipment.[60]

3.40. To add to the issues facing buyers, there were occasions where the applicable specifications changed or officials were asked urgently to buy items with new specifications.[61] In each case, they had to understand, interpret and apply the new specifications under the pressure of the pandemic.

54 INQ000581862_0003 para 7
55 INQ000581862_0001-0003 paras 2, 7
56 INQ000581862_0003 para 7; INQ000560897_0083-0084 paras 312-316; INQ000529575
57 INQ000536422_0007 para 19; INQ000527570_0007, 0014 paras 2.10, 4.8
58 INQ000581862_0001-0003 paras 2, 6; 'Innovative PPE protecting frontline staff', Southampton Biomedical Research Centre (https://www.southamptonbrc.nihr.ac.uk/impact-case-study-v4-2/innovative-ppe-protecting-frontline-staff; INQ000549364)
59 INQ000540488_0012 para 3.27
60 INQ000540488_0012 para 3.27
61 INQ000540488_0012-0013 para 3.28; INQ000528391_0131 para 485

3.41. From April 2020, the PPE Cell was given the assistance of a dedicated technical assurance team of experienced quality assurance professionals.[62] To assist with interpreting the technical specifications (which generally referred to the applicable regulations for each type of healthcare equipment), a Decision Making Committee (see above) comprising a range of bodies including healthcare equipment regulators was established.[63] However, other buyers of PPE – such as NHS trusts in England supplementing their PPE supplies and local authorities that bought PPE for the care sector – did not have access to such expertise and so struggled to navigate through the regulations and technical specifications on their own.[64]

3.42. Daniel Mortimer, Deputy Chief Executive of the NHS Confederation and Chief Executive Officer of NHS Employers between 2014 and 2026, told the Inquiry that NHS staff, including GPs, were frustrated by regulatory rules that were difficult to navigate as they desperately tried to source PPE. He told the Inquiry that he made a "*plea for the rules to be simplified, and to be made more accessible and more rapidly deployable*".[65]

3.43. Buyers of healthcare equipment, whether they are part of an emergency government procurement effort or operating within the health and social care sectors, need either the expertise or the written guidance to be confident that they are buying safe equipment.

3.44. Mr Russell told the Inquiry that either the regulations or the applicable guidance "*could have been clearer*".[66] The Inquiry agrees – they should have been made clearer sooner.

3.45. Many of the problems experienced by suppliers, buyers and end-users were caused by complex regulations and difficulties in their interpretation and application.[67] Each regulation and standard may have originally had a specific purpose intended to ensure safety, but the result was a labyrinth of rules that those involved in procurement and distribution were required to navigate during a crisis.

3.46. Rules that apply in non-pandemic times are not necessarily appropriate for emergencies such as the Covid-19 pandemic. In future, there needs to be a specific focus on how PPE and other healthcare equipment will be used in a pandemic, and on ensuring that regulations are not unnecessarily hindering the production, procurement and distribution of vitally needed equipment due to their complexity. As Lord Deighton told the Inquiry:

62 INQ000540488_0019 para 3.47(b)
63 INQ000540488_0012-0013 para 3.28; INQ000528391_0130 para 482
64 INQ000520830_0010, 0027 paras 37, 117; INQ000472553
65 Daniel Mortimer 18 March 2025 11/6-7
66 Graham Russell 12 March 2025 63/8-10, 65/18-22, 66/1-2
67 INQ000517443_0020-0021, 0023-0024, 0026, 0040-0041 paras 7.4, 7.6, 7.17-7.20, 8.2, 8.45

> "[T]*he whole point about safety is that it's a slow and highly deliberate process. We still needed deliberate but we didn't need slow.*"[68]

3.47. It would take valuable time to draft regulations in the midst of an emergency. Pandemic planning should include consideration of where equipment is going to be used in a pandemic and the boundaries in the regulations should be set accordingly. Safety must always be the priority. A simplified and streamlined set of UK-wide emergency healthcare equipment regulations, capable of being adapted and passed into law in future pandemics, should be drafted and published. These regulations should identify clearly which regulator is responsible for each particular type of healthcare equipment and the minimum technical specifications should be focused exclusively on the equipment's use in a pandemic.

3.48. The regulations applicable to healthcare equipment in an emergency need to be communicated clearly and concisely to suppliers, buyers and end-users.

3.49. In Wales, in a joint endeavour by the British Safety Industry Federation (a trade association for the safety industry) and the National Procurement Service of the Welsh Government, a buyer's guide was launched in June 2020. This included illustrated examples of how to spot counterfeit certificates of compliance.[69] This was a good example of a tool that provided practical assistance to those responsible for procurement. It is a useful template for a UK-wide pandemic buyer's guide that may also be used by suppliers and end-users to help them understand the applicable regulations.

Proliferation of guidance

3.50. A lack of guidance may combine with a complex system (albeit one designed to ensure safety) to create barriers to entry for potential manufacturers and suppliers of healthcare equipment. This may slow down and limit supplies. Too much guidance can also cause confusion and create unnecessary hurdles. An appropriate balance needs to be found.

3.51. Before the pandemic struck, the Medicines and Healthcare products Regulatory Agency, the Health and Safety Executive, the Health and Safety Executive for Northern Ireland and the Office for Product Safety and Standards failed to have plans in place for how they would approach regulation during a pandemic. This led Nigel Boardman, later Sir Nigel Boardman (who was appointed by the UK government to conduct a review of pandemic procurement), to recommend the writing of a "*crisis manual*" for regulators.[70] The absence of such plans led to a proliferation of written

68 Paul Deighton 18 March 2025 75/15-18
69 INQ000198576_0001, 0006
70 *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021, p30 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876); INQ000587046_0003 para 5

guidance from different regulators as they responded to issues as they arose, from technical specifications to the recognition of international safety marks.[71]

3.52. The regulators jointly produced guidance for manufacturers on the essential technical requirements for non-'CE'-marked PPE (a certification mark affixed by manufacturers to demonstrate compliance with EU safety regulations) being procured directly by the PPE Cell for healthcare workers.[72] It was designed to focus on core criteria, such as filtration quality, splash resistance and fit, in order to speed up supply where easements (discussed below) already applied. Some products did not have a relevant standard, so regulators had to develop this during the pandemic.[73]

3.53. This guidance was not initially fit for purpose and had to be revised on several occasions.[74] It assumed technical knowledge among manufacturers and lacked clarity about the evidence that needed to be submitted to the regulators. For equipment to be purchased by the PPE Cell, the regulators' guidance had to be read alongside separately issued infection prevention and control guidance.[75] As examined in Module 3, infection prevention and control guidance, which focused on preventing the spread of Covid-19, was revised and amended several times during the pandemic as the understanding of the mode of transmission changed.[76] This placed a heavy burden on health and care workers, including those who were trying to ensure that their colleagues were obtaining and using the right PPE in the right way.[77]

3.54. The British Safety Industry Federation explained that there was confusion among manufacturers as successive pieces of guidance were issued, with the effect that it was "*often difficult to know*" how to demonstrate compliance.[78] There was confusion not only among manufacturers but also among regulators and end-users.[79]

3.55. While updates to written guidance as information about a pandemic develops may well be helpful, the risk of causing confusion among recipients by their proliferation should be carefully considered. The regulators should coordinate and plan the issuing of guidance to ensure that it is clear, concise and only issued when it is both of real assistance and absolutely necessary.

71 INQ000560897_0017-0018, 0031-0032 paras 62, 109-110, 114-115; INQ000508352_0001
72 INQ000475453_0003 para 5; INQ000269668
73 INQ000560897_0017-0018 para 62
74 INQ000517443_0099-0100 para 14.11
75 INQ000517443_0099 para 14.11(a)
76 INQ000520830_0013 para 54; INQ000269707_0009-0010 paras 5.1.6-5.1.8; INQ000528391_0004 para 10; INQ000541374_0006 para 24; *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026, Chapter 1 (https://covid19.public-inquiry.uk/documents/module-3-full-report)
77 INQ000520830_0015-0016 paras 62-69
78 INQ000539148_0005 para 18
79 INQ000539148_0005 para 18

Balancing safety and innovation

3.56. When ministers, officials, regulators and suppliers are required to work together closely and under pressure to ensure that vital healthcare equipment is available in a pandemic, there is a risk that safety standards may be compromised in the interests of speed and efficiency.

3.57. In the procurement of PPE, as Lord Deighton explained to the Inquiry, regulators were prepared to be "*flexible*" and "*pragmatic*", while upholding safety standards.[80]

3.58. The Ventilator Challenge (see Chapter 2: Emergency procurement and distribution during the pandemic) took a number of innovative and practical steps in bringing together regulators, clinicians, project managers and industry to streamline the regulatory approval process. The Technical Design Authority, which made recommendations to ministers on proposed suppliers' ventilator designs, brought in the Medicines and Healthcare products Regulatory Agency at an early stage of product development, to embed safety at the centre of the procurement process.[81]

3.59. The Medicines and Healthcare products Regulatory Agency set up 'Team Vent' on 13 March 2020 to manage and prioritise its activities relating to supporting the Ventilator Challenge. It also developed an expedited assessment process specifically for the Ventilator Challenge.[82] Close collaboration between the regulatory team and engineering teams in the Ventilator Challenge allowed real-time feedback as well as concurrent testing and design iterations. There were dedicated points of contact at the Cabinet Office, available project management and design specialists, and supply chain, manufacturing development and legal and auditing support.[83] This showed that regulatory flexibility could be maintained without compromising patient safety. The approach taken in the Ventilator Challenge helped potential suppliers navigate the regulatory approval process.

3.60. One of the companies that participated in the Ventilator Challenge was Dyson Ltd, a leading designer and manufacturer of household appliances.[84] It had the engineers, supply chain and manufacturing capability to be a potentially successful supplier of a new ventilator, and was paired by officials with a designer for its ventilator prototype.[85] The Dyson Ltd order was contingent on the design and its associated manufacturing system being approved by the Medicines and Healthcare products Regulatory Agency.[86] Ministers, including Boris Johnson MP (Prime Minister from July 2019 to September 2022) and Michael Gove MP, later Lord Gove (Chancellor of

80 Paul Deighton 18 March 2025 82/19-83/1
81 INQ000497031_0073 paras 4.42.2, 4.44.1; INQ000541374_0039 para 140
82 INQ000541374_0035, 0038-0039 paras 123, 139
83 INQ000497031_0079 paras 4.57-4.58
84 INQ000535017_0036-0037 para 103
85 INQ000528389_0107 para 5.20
86 INQ000535017_0040-0041 para 109; INQ000497031_0077 para 4.51.3; INQ000569124_0022-0023 para 76.3

the Duchy of Lancaster from July 2019 to September 2021), encouraged officials to facilitate the purchase of ventilators from Dyson Ltd.[87]

3.61. Procurement officials and regulators ensured that, even under the pressure to supply ventilators to the NHS at the peak of the pandemic, the regulations and regulatory process were followed.[88] The ventilator was assessed as being less clinically viable than others and no contract was awarded to Dyson Ltd.[89] Despite the huge pressure on them, officials and regulators ensured that safety standards could be effectively upheld.

3.62. In the procurement of lateral flow tests, the Medicines and Healthcare products Regulatory Agency innovated by issuing specific written guidance for manufacturers.[90] Rather than setting predetermined standards and potentially constraining suppliers, the agency acted to accelerate the development and evaluation of new diagnostic technologies by supporting new product designs, encouraging research and development, facilitating discussions with regulators and using scientific expertise as understanding of the pandemic developed.[91] This approach to developing testing equipment was "*found to be of value in many countries*".[92]

3.63. The Ventilator Challenge and the procurement of testing equipment are examples of innovation in healthcare equipment where the regulator acted quickly and decisively to facilitate new developments in healthcare technology, while ensuring that safety was not compromised. The Medicines and Healthcare products Regulatory Agency suggested that, in future, there should be "*earlier consultation during the procurement process to enable proactive development of technical specifications*".[93] The Inquiry agrees.

3.64. In a pandemic, there will almost certainly be significant pressure from ministers on officials and regulators to expedite the procurement of potentially life-saving healthcare equipment. There is an appropriate balance to be struck between ministerial leadership and the potential for improvements in regulations, safety standards and the approvals process.

3.65. New and innovative suppliers should be encouraged to work with government and regulators during a pandemic. Ministers should provide appropriate leadership, but regulators must remain as the independent arbiters of minimum, non-negotiable safety standards. The pandemic showed that government and industry could

87 INQ000528389_0106 para 5.19; INQ000233775_0001; INQ000048399_0014; INQ000496699; INQ000533247; INQ000535017_0036-0037 para 103
88 INQ000535017_0036, 0039-0041 paras 102, 108-109; INQ000497116_0002; INQ000513540_0001; INQ000536361_0013 para 62; Michael Gove 10 March 2025 121/18-123/3
89 INQ000535017_0042-0043 para 112
90 INQ000541374_0052 para 186
91 INQ000541374_0029 paras 100-101
92 INQ000541374_0029-0030 para 102
93 INQ000541374_0063 para 228

effectively balance safety and innovation. Pandemic planning by regulators should include flexible engagement between government, suppliers and regulators.

Inspection and easements

3.66. The adequate inspection of healthcare equipment before it reaches health and social care workers is critical to keeping them safe. There is a trade-off between the speed at which healthcare equipment may be procured and distributed and making inspections to assure the safety of the equipment. This may slow supply down. An effective emergency procurement and distribution system has to strike an appropriate balance between speed and safety throughout the process. This requires planning.

3.67. Exceptional use authorisations and easements provide legal routes to speed up the process by which PPE and medical equipment reach the market in the interests of the protection of public health.[94]

3.68. Exceptional use authorisations allow manufacturers of medical devices to depart temporarily from usual conformity assessments under a process tightly controlled by regulations.[95] Those regulations require manufacturers to report monthly to the Medicines and Healthcare products Regulatory Agency, informing it of how many devices have been provided, and to whom, under the exceptional use authorisation and to report any adverse incidents involving the device.[96]

3.69. Easements were permitted by the Health and Safety Executive if products met essential safety requirements, temporarily removing the need for compliance assessments prior to sale.[97] They were only granted in certain circumstances, such as where PPE met recognised international standards and for fixed time periods.[98] A conformity assessment was still required, but this would be carried out by the Health and Safety Executive and, once an easement was granted, no further assessments were required for the product.[99]

3.70. In March 2020, EU systems of regulatory easement were activated by the European Commission and adopted in the UK.[100] To meet the urgent need to deliver PPE and

94 In England, Scotland and Wales, exceptional use authorisations are made under The Medical Devices Regulations 2002 (https://www.legislation.gov.uk/uksi/2002/618/contents). In Northern Ireland, Regulation (EU) 2017/745 of the European Parliament and of the Council (https://www.legislation.gov.uk/eur/2017/745/contents) additionally applies, alongside The Medical Devices Regulations 2002 and The Medical Devices (Northern Ireland Protocol) Regulations 2021 (https://www.legislation.gov.uk/uksi/2021/905/contents). See also Commission Recommendation (EU) 2020/403 of 13 March 2020 on conformity assessment and market surveillance procedures within the context of the COVID-19 threat (https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1584691656525&uri=CELEX:32020H0403); The Personal Protective Equipment (Temporary Arrangements) (Coronavirus) (England) Regulations 2020 (https://www.legislation.gov.uk/uksi/2020/1484/contents/made).
95 INQ000517443_0059-0060 para 10.13
96 INQ000541374_0031 para 109
97 INQ000517443_0026, 0030 paras 8.1, 8.19
98 INQ000560897_0037 para 141
99 INQ000560897_0037-0038 paras 143-145
100 INQ000517443_0026-0030 paras 8.1-8.18

medical devices to the health and social care sectors, several steps were taken, including the introduction of:

- easements removing the requirement for CE markings;[101] and
- exceptional use authorisations granted by the Medicines and Healthcare products Regulatory Agency allowing medical devices to be used without a CE marking, subject to risk assessments, in the absence of alternatives if there was an immediate clinical need for the device.[102]

3.71. The easement process reduced the conformity assessment time for some products from two to three months to one to two months.[103] The average approval time for masks without an easement was about 12 weeks; the average time under easements was approximately two weeks at the beginning of the pandemic and about five weeks by November 2020.[104] However, it did not lead to a streamlined, efficient process for PPE to reach end-users.[105] This was because:

- Easements led to "*significant*" confusion among manufacturers, including identifying which regulator was in charge.[106]
- Time saved by streamlining regulation in this way was lost as equipment needed to be more thoroughly inspected.
- Easements could be easily abused by unscrupulous suppliers evading the regulators.
- Regulators found them difficult to police as large volumes of PPE were imported with little or no paper trail to indicate that the manufacturer had complied with safety standards.[107]

3.72. One of the difficulties for buyers was inspecting and spotting counterfeit PPE and forged certificates. Expert scrutiny of these certificates could sometimes only take place after the item in question had been physically inspected and compared with the certificates. This prevented the immediate release of PPE bought by the Department of Health and Social Care.[108] Fraudulent PPE, which could involve the forging of safety certificates as well as "*fictional*" testing bodies, was very difficult for procurement teams to detect, as fake testing certificates were very convincing to the untrained eye.[109]

101 INQ000560897_0018-0019 paras 65-67; INQ000517443_0026-0027 paras 8.4, 8.8
102 INQ000541374_0031-0033 paras 109-116
103 INQ000517443_0044-0045 para 8.56
104 INQ000517443_0043 para 8.52
105 Commission Recommendation (EU) 2020/403 of 13 March 2020 on conformity assessment and market surveillance procedures within the context of the COVID-19 threat (https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32020H0403&qid=1777369582129)
106 INQ000539148_0005 para 18; INQ000517443_0098-0099 para 14.10(b); INQ000475453_0007-0008 para 21
107 INQ000517443_0029 para 8.15; INQ000477765_0035
108 INQ000560897_0051 para 194
109 INQ000539148_0008 paras 27-28

3.73. In April 2020, procurement officials in the PPE Cell were requested by more senior officials to "*take slightly more risk on due diligence*" by relaxing technical assurance (ie the examination of evidence submitted by suppliers that equipment complied with the regulations).[110] This was to avoid losing offers by conducting time-consuming compliance checks prior to placing an order. As examined in Chapter 6: Transparency, governance and accountability, although it came with a higher risk of buying PPE that was unsafe and therefore unusable, this emergency spending was approved by the Treasury.[111]

3.74. The purchase of PPE from new suppliers without inspection prior to purchase – combined with the use of tools such as exceptional use authorisations, easements and taking more risk on due diligence – increased the risk that unsafe PPE was purchased.[112] The trade-off in increasing the speed and scale of buying PPE in this way was that, once the equipment was delivered to the UK, more physical inspections had to be conducted to ensure that only safe PPE reached end-users in the health and social care sectors.

3.75. The overall effect was a significant backlog at the distribution centre of Clipper Logistics plc (the company contracted to manage warehousing arrangements) in Daventry. By 9 April 2020, approximately 4.5 million units of PPE were awaiting inspection and clearance.[113] To clear this backlog, a team from the Ministry of Defence and regulators (led by the Health and Safety Executive) carried out checks.[114] While the most acute backlog was eased during April, the quality assurance process took a long time and it was not until October 2020 that a faster and more formal assurance process was established.[115] By December 2020, 12.69 billion (about 42%) of the 30 billion items of PPE held by the UK government or to be delivered had passed quality assurance.[116] By April 2022, 96.6% of stock had been quality-assessed and 7.5% was categorised as 'not for onward supply' to the health and social care sectors.[117]

3.76. A more rigorous inspection process was established at the Daventry distribution centre in April 2020. It required regulators to take on responsibilities, such as undertaking inspections and advising on compliance, that were outside their normal remit.[118] The results of the inspections were manually logged on a spreadsheet by different entities: Clipper Logistics plc, the Office for Product Safety and Standards, the Health and Safety Executive, the Medicines and Healthcare products Regulatory Agency, the Army and Supply Chain Coordination Ltd.[119]

110 INQ000106355_0003-0004; INQ000528391_0130-0132 paras 481-487
111 INQ000574180_0003 para 14
112 INQ000517443_0052-0055 paras 9.18, 9.23, 9.29; INQ000528391_0092-0093, 0211-0212 paras 343, 786-793; INQ000106355_0003-0004
113 INQ000517443_0053 para 9.23
114 INQ000517443_0053 para 9.23; INQ000538647_0011-0015 paras 31-40
115 INQ000528391_0211 para 788
116 INQ000528391_0211 para 789
117 INQ000528391_0212 para 793
118 INQ000541374_0016 para 50; INQ000517443_0052-0053 paras 9.18, 9.28-9.30; INQ000478738
119 INQ000560897_0027, 0045-0046 paras 97, 173; INQ000475349

3.77. When the Office for Product Safety and Standards inspected operations in April 2020, it found significant issues, with many items needing to be checked because it was not known what items existed or their quality or value.[120] The regulators deployed teams of officials who, working with the Ministry of Defence, developed, streamlined and improved processes.[121] However, in July 2020, the Health and Safety Executive was still concerned that PPE was being released without quality assurance checks being completed, and identified instances of items being distributed that were non-compliant or had not been inspected.[122]

3.78. Prior to the pandemic, the UK did not have accredited testing houses (bodies that subject materials used for healthcare equipment to safety tests) for all items of PPE. Each type of PPE required a different testing house and a different type of testing to be deemed safe. Normally, this was done through testing houses based in Europe – there was, for example, only one accredited testing house for FFP3 masks in the UK.[123] Although the regulators, the Department of Health and Social Care and the Department for Business, Energy and Industrial Strategy liaised with testing houses to prioritise batches and products to get urgently needed items to health and care settings, the capacity of testing houses to check PPE compliance was limited throughout the pandemic.[124]

3.79. The UK government increased funding for testing houses; encouraged procurement teams to buy from suppliers that had already carried out testing; and booked testing slots in advance of shipping.[125] It also explored the use of testing houses outside the UK and making use of Ministry of Defence facilities, as accrediting new testing houses would have taken too long.[126] The relatively small number of testing houses in the UK could not keep pace with the increasing volume of PPE being procured.[127] They sought to increase their capacity by increasing staff and working hours, but this was not sustainable.

3.80. By July 2020, although there was spare capacity for testing isolation gowns, eyewear and medical gloves, waiting times for testing surgical gowns were between three months and one year.[128] This was an unacceptable delay.

3.81. Tim Jarvis (Director of PPE Make at the Department for Business, Energy and Industrial Strategy from April 2020 to September 2020), who was working with domestic manufacturers of PPE as part of the UK Make programme, told Lord Deighton and others in an email on 22 May 2020 about the regulatory system:

120 INQ000475327_0002
121 INQ000560897_0026-0027 paras 93-95; INQ000517443_0055 para 9.32; INQ000475349
122 INQ000560897_0046 paras 175-176
123 INQ000066032_0004
124 INQ000517443_0079-0080 paras 12.66, 12.71
125 INQ000475452_0001-0002
126 INQ000475317; INQ000508352_0003
127 INQ000478738
128 INQ000475452_0004

> "[It] *does not work and is not set up to deliver pragmatic decisions which appropriately balance the need to ensure the safety of front line staff with an efficient process which gets suitable kit to where it is needed at pace.*"[129]

3.82. The streamlining of regulatory requirements and the application of less rigorous technical assurance checks during the procurement process to speed up the procurement and distribution of PPE almost certainly carry with them the increased risk that more non-compliant equipment enters the market and reaches end-users. In a future pandemic, this risk should be mitigated with better planning by regulators to increase testing house capacity and the deployment of a more robust inspection regime, in proportion with any lighter-touch approach to regulation. Balancing speed and safety in a pandemic requires a plan for the whole regulatory and inspection system.

Enforcement

3.83. In normal times, healthcare equipment is generally procured from longstanding, trusted and reliable suppliers by the central procurement bodies across the UK (see Chapter 2: Emergency procurement and distribution during the pandemic). During the pandemic, increased risk to the safety of end-users was caused by the breakdown in trusted supply chains and the entry into the global market of new manufacturers and suppliers of PPE.[130] There was a lower guarantee of quality.[131] Due to the sheer volume of material that was circulating and the increased risk once PPE entered the global market, it was a significant challenge to enforce regulations to ensure that only safe and compliant PPE entered the UK.

3.84. Enforcement was addressed principally by the interception of goods at the UK's borders and by end-users making reports of potentially unsafe PPE to regulators.

3.85. In May 2020, the Office for Product Safety and Standards – together with 16 local authority trading standards teams and Border Force – launched Operation Safeguard to intercept shipments in relation to high-risk suppliers of unsafe PPE entering the UK through ports and airports.[132] However, the effectiveness of Operation Safeguard depended on the capability, capacity and coordination of individual trading standards teams, as they were embedded in local authorities around the UK rather than within a single organisation. For example, at Heathrow Airport intervention could involve five local authority trading standards teams because freight was cleared through warehouses in different locations.[133]

129 INQ000475400_0002
130 INQ000474864_0011, 0086 para 48, Section Summary for Section 5
131 INQ000560895_0024-0025 para 77
132 INQ000517443_0021, 0047-0048 paras 7.5(e), 9.2-9.4
133 INQ000475359_0001 para 4

3.86. While relationships were established between Border Force, local authority trading standards teams and the Office for Product Safety and Standards during the pandemic, these relationships were better in some places than others.[134] Local authorities had "*limited capacity to respond effectively*" due to the significantly increased volume of goods entering the UK and their limited staff and resources.[135] Interception of non-compliant or unsafe healthcare equipment at Heathrow Airport was more successful. At other airports, engagement between the large number of different teams within regulators and law enforcement bodies was less well developed.[136]

3.87. Although, during Operation Safeguard, 40.1 million items of PPE were inspected and 4 tonnes of PPE were removed from the UK supply chain, the Office for Product Safety and Standards acknowledged that "*high volumes of potentially non-compliant, ineffective or unsafe PPE*" entered the market.[137]

3.88. During the pandemic, other regulators including the Health and Safety Executive undertook their own enforcement action.[138] However, this was not part of any broader plan to coordinate action between regulators and law enforcement bodies.

3.89. Data about non-compliant PPE were held by multiple regulators and law enforcement agencies in different systems. Many bodies, including the British Safety Industry Federation, local authority trading standards teams and local law enforcement agencies, as well as manufacturers, referred concerns about suspicious traders or shipments to the Office for Product Safety and Standards.[139] However, trading standards teams had limited access to the intelligence gathered about these shipments.[140] Trading standards teams' inspections and interventions were logged separately on spreadsheets and tracked manually, and there were no effective intelligence-sharing systems between local trading standards bodies.[141]

3.90. The systems for reporting non-compliant PPE to the Medicines and Healthcare products Regulatory Agency and the Health and Safety Executive were not easy for health and social care workers to use. Rosemary Gallagher, Professional Lead for Infection Prevention and Control and Nursing Sustainability at the Royal College of Nursing from July 2009 to July 2025, told the Inquiry that nurses raised concerns about how time-consuming the process of reporting non-compliant or unsafe PPE was. It had to be "*reported through multiple routes*", which took "*an extraordinary amount of time*" and "*they rarely heard anything back*" from those responsible for enforcement.[142]

134 INQ000475359_0001
135 INQ000475359_0001 para 3
136 INQ000517443_0049 para 9.7; INQ000475485_0009
137 INQ000475359_0001 para 2; INQ000477765_0034; INQ000517443_0048 paras 9.5, 9.7
138 See, for example, the powers of the Health and Safety Executive (INQ000560897_0014-0015 paras 48-53).
139 INQ000517443_0048 para 9.5
140 INQ000475359_0006
141 INQ000517443_0047, 0049 paras 9.2, 9.6
142 Rosemary Gallagher 18 March 2025 51/15-19

3.91. Key measures for ensuring that unsafe and non-compliant PPE does not enter the UK in a future pandemic include:

- effective intelligence-gathering and sharing between healthcare equipment regulators and law enforcement bodies such as Border Force and trading standards bodies or teams (examined in Chapter 7: Data, technology and the future of emergency procurement); and
- a coordinated programme of enforcement at the UK's borders.

3.92. The Office for Product Safety and Standards now operates a Border Programme which seeks to provide a more coherent approach to the enforcement of regulations across the UK's ports and airports.[143] This should in future be capable of rapidly increasing its capability and capacity in the event of a pandemic and coordinating with other regulators and law enforcement bodies to detect and deter unscrupulous suppliers seeking to import non-compliant and unsafe healthcare equipment into the UK. This is a positive development.

Emergency healthcare equipment regulations and a pandemic plan

3.93. The regulatory system for PPE is a complex patchwork of regulators and inspection and enforcement bodies. The rules and regulations about the standards for PPE and advice on the circumstances in which it should be used are set out in several pieces of legislation and guidance. Even after the introduction of easements, the regulations governing medical devices and PPE meant that suppliers, buyers and end-users had to engage with detailed technical requirements, differing international and EU-wide standards, and different regulators and certification bodies. This remained the case after steps were taken to ease some of the regulatory requirements. It was too difficult for regulators, buyers, suppliers and end-users of healthcare equipment to navigate the system effectively in the pressurised context of the pandemic. It caused delays and confusion among regulators, and created barriers to entry for new suppliers of healthcare equipment.

3.94. A set of simplified emergency healthcare equipment regulations should be drafted and published by the UK government and devolved administrations. The regulations should establish the minimum technical specifications of healthcare equipment for a pandemic and set out clearly the roles and responsibilities of the regulators. The focus of the regulations must be on how healthcare equipment will be used in health and social care settings in a pandemic. These emergency healthcare equipment regulations should be accompanied by a clear and concise buyer's guide that is easily understood by procurement officials, suppliers and end-users in the health and social care sectors.

143 INQ000517443_0049 para 9.7

3.95. While there will always be some uncertainty about the types of healthcare equipment that will be needed, the regulations should be aligned with the range and severity of pandemic risks set out in the National Security Risk Assessment (the main tool for assessing the most serious civil contingency risks facing the UK) and capable of adapting to the circumstances of the next pandemic.

Recommendation 4: Emergency healthcare equipment regulations

The UK government and devolved administrations should publish simplified regulations for emergency healthcare equipment that are aligned with and cover the range and severity of pandemic risks identified in the National Security Risk Assessment.

The simplified regulations should:

- establish the minimum technical specifications of healthcare equipment specifically for use in a pandemic, including international standards that are recognised in the UK;
- clearly identify the regulator responsible for coordinating regulation, inspection and enforcement for each type of equipment; and
- be accompanied by a buyer's guide that is easily understood by procurement officials, suppliers and end-users in the health and social care sectors.

The emergency healthcare equipment regulations and the buyer's guide should be kept under review and updated in line with relevant changes to the National Security Risk Assessment.

3.96. The difficulties caused to suppliers by the regulatory complexity were compounded by the issuing of several pieces of written guidance by different regulators. In a future pandemic, regulators should plan and coordinate the issuing of guidance to ensure that it is clear, concise and necessary.

3.97. Decisions taken during the pandemic to relax due diligence at the procurement stage and provide for legal routes to speed up the time it took for healthcare equipment to reach the market were not matched by a suitable testing and inspection regime. The UK regulators of healthcare equipment should establish a pandemic plan to increase testing house capacity and inspections in an emergency so that the procurement and regulatory systems are better aligned.

Recommendation 5: An emergency healthcare equipment plan

UK regulators, including the Health and Safety Executive, the Health and Safety Executive for Northern Ireland, the Office for Product Safety and Standards and the Medicines and Healthcare products Regulatory Agency, should establish an emergency healthcare equipment cross-regulator plan for future pandemics.

The plan must include arrangements for:

- coordination of written guidance from regulators to ensure that it is clear, concise and updated when required; and
- increasing testing house capacity and the deployment of suitable inspection regimes both to reduce the quantity of non-compliant equipment entering the system and to improve enforcement.

Chapter 4: Global supply chains and domestic industrial resilience

Introduction

4.1. The production of healthcare equipment relies on a global network of suppliers of raw materials, manufacturers and distributors cooperating and competing in the open market to meet the demands of end-users. The links between participants in the network form global supply chains that fluctuate and adapt depending on the prevailing conditions of the market. The Covid-19 pandemic created a frenzied market.

4.2. Countries around the world sought to prioritise and protect their own citizens and began to escalate their buying. Exporting nations requisitioned personal protective equipment (PPE) and applied export controls to key healthcare equipment and supplies. Lockdowns in key countries supplying healthcare equipment caused disruption to manufacturing and exports, while border closures created obstacles to global distribution.

4.3. This created a near-perfect 'storm' as governments realised the sheer quantity of PPE and other healthcare equipment that would be required to respond to the pandemic and scrambled to acquire it in enormous volumes. This drove an exponential rise in demand for PPE around the world.[1]

4.4. As global supply chains came under enormous strain, governments across the world, including the UK government and devolved administrations, opted to increase their domestic manufacturing of healthcare equipment. This chapter examines the UK's reliance on global supply chains for healthcare equipment, the approach to scaling up the domestic production of healthcare equipment in response to the Covid-19 pandemic, and how the UK government and devolved administrations should limit their exposure to the risks of global market dysfunction in the future.

Reliance on global supply chains

4.5. In common with many other western nations, much of the UK's domestic manufacturing capacity has been relocated abroad, especially in high-volume, low-value sectors such as PPE.[2] In non-pandemic times, the UK's supply of healthcare equipment relies almost exclusively on overseas manufacturers and distributors.[3] The offshoring of manufacturing was a trend for many decades prior to the pandemic, primarily to take advantage of lower labour costs and large and rapidly scalable workforces.[4] Supply to the UK relies on the effective functioning and resilience of complex networks of supply chains operating across borders and

1 INQ000565791_0003-0004 paras 7-8
2 INQ000474864_0025 para 107; INQ000527570_0012-0013 para 4.1
3 INQ000474864_0081 para 335; INQ000527570_0012-0013 para 4.1
4 INQ000474864_0017 para 72; INQ000527570_0012-0013 para 4.1

involving multiple layers of suppliers of raw materials, manufacturers and distributors collaborating and competing with each other.[5]

4.6. In a global trading system generally based on the principles of open and free trade, what is produced, by whom and at what cost are determined to a significant degree by the market. The domestic manufacturing and international trading capabilities, capacities and policies of sovereign nation states and trade blocs determine the shape of the market.

Risks of supply chain concentration

4.7. Modern supply chains for healthcare equipment in the UK and globally are reliant on overseas suppliers, particularly those based in Asia and most frequently in China.[6] China accounts for 40% to 60% of global production of coveralls, masks, aprons and eye protection and only slightly lower levels in other sectors.[7] Before the Covid-19 pandemic, the medical gloves market was the exception, with Malaysia and Thailand together accounting for 85% of global production, principally on account of their proximity to the rubber necessary for production.[8] The USA was the only other major manufacturing nation in most PPE sectors, accounting for 20% to 25% of supply.[9]

4.8. The way in which the global market for healthcare equipment is structured means that much of the world is heavily reliant on China.[10] In non-pandemic times, this has resulted in cheap and generally reliable supplies. However, it has left the UK government and devolved administrations exposed to risks – particularly in an emergency – arising from, for example, manufacturing capacity and changes to international trade policies and practices in China. These risks are aggravated by the lack of a wide range of alternative countries from which to source equipment and by the international transport disruption caused by a global health emergency.[11] The concentration of many manufacturers in a single country – and the UK's reliance on them – was and remains a "*major risk*".[12]

4.9. Sizeable production of healthcare equipment exists in other individual markets, such as France and Germany, but not in the UK.[13] Western nations that have retained a domestic manufacturing capacity in low-value but high-volume products such as PPE rely on automation and new technologies to compete with lower-cost producers.[14] This allows them to retain a sovereign domestic capability, which was scaled up when the Covid-19 pandemic struck.

5 INQ000474864_0015 para 66
6 INQ000474864_0006, 0008 paras 18, 31-32; INQ000527570_0012-0013 para 4.1; INQ000563395_0017-0018 para 74
7 INQ000474864_0008, 0056 paras 31, 230
8 INQ000474864_0056 para 232
9 INQ000474864_0056 para 231
10 INQ000474864_0008, 0057 paras 28, 31, 234
11 INQ000474864_0059-0063, 0091-0094 paras 251-260, 377-393
12 INQ000474864_0009 para 32
13 INQ000474864_0056 para 233
14 INQ000474864_0008 para 31

4.10. While the UK does not compete in terms of cost with manufacturers of healthcare equipment such as PPE in Asia – and specifically China – it does excel at producing high-value products, with high levels of sophistication and technology.[15] The sector involves 2.6 million workers, accounting for £217 billion of gross domestic product; the UK ranks as the 12th largest manufacturing nation in the world.[16] The UK had a manufacturing base which, when circumstances in the pandemic required, was willing and able to assist in the response to the pandemic. In the lockdown between March and July 2020, many of these domestic manufacturers ceased operations and their staff were furloughed, which meant there was a latent manufacturing capacity and an opportunity for UK industry to step into the production of healthcare equipment.[17]

Disruption to global supply chains

4.11. A combination of various factors led to a reduction in exports of PPE from China in January and February 2020, while exports of PPE to China from the rest of the world increased.[18] As the Chinese government prioritised domestic needs, the level of international supplies of PPE fell further.[19] The governments of other producer nations unsurprisingly prioritised the provision of key healthcare equipment and supplies to their own citizens and export restrictions were imposed.[20]

4.12. As fierce competition for the equipment sold on the open international market ensued, at the same time as Covid-19 restrictions on manufacturing capacity took hold and international logistics were disrupted, global prices rose exponentially.[21] The export prices for certain categories of PPE manufactured in China increased by between 32.4% and 1,252%.[22] Those responsible for the procurement of healthcare equipment in the UK in the early stages of the pandemic had virtually no control over the restrictions on supply and the price rises; their choice was essentially between buying at the inflated price or not buying at all.

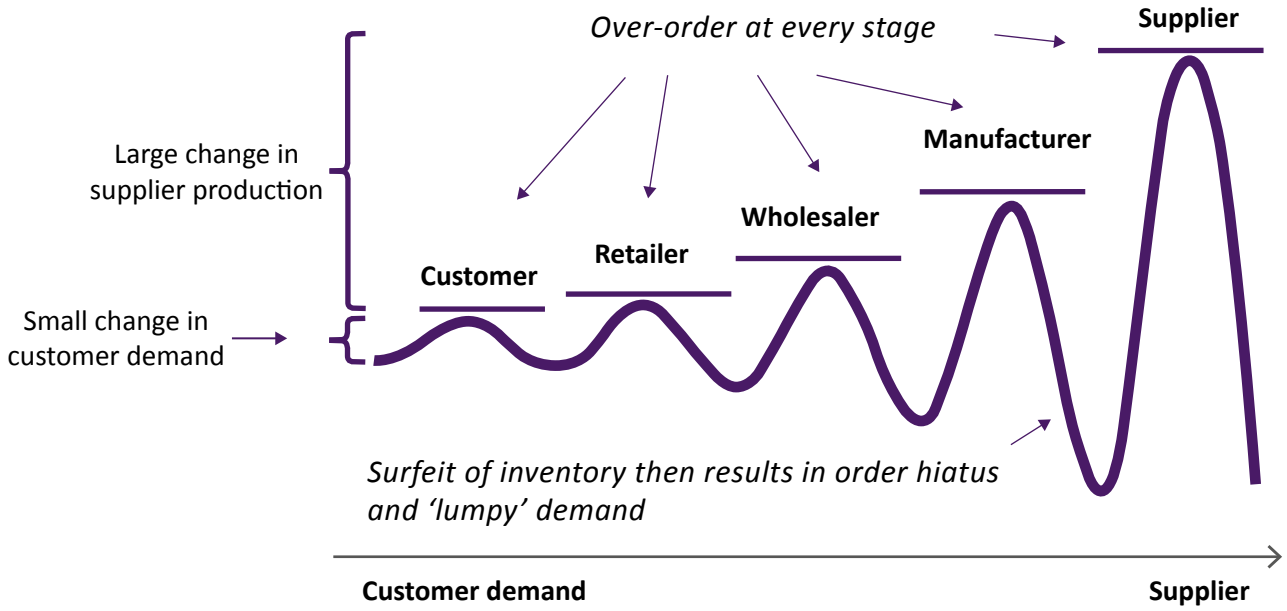
4.13. At the same time, the supply chains on which the UK usually relied came under strain and effectively broke down, rendering the UK government and devolved administrations vulnerable to supply shortages.[23] Procurement officials in the UK were unable to guarantee the purchase and delivery of PPE at the speed and scale necessary to ensure that health and social care workers and the wider public did not run out of critical equipment.[24] This was foreseeable.

15 INQ000474864_0081 para 335
16 INQ000474864_0081 para 335
17 INQ000527570_0005 para 2.6
18 INQ000474864_0090 para 371
19 INQ000474864_0011 para 46; INQ000528391_0073 para 271
20 INQ000474864_0040 para 161; INQ000563395_0002 para 7; INQ000528391_0073, 0078 paras 271-272, 293; INQ000492085_0028 para 9.2
21 INQ000474864_0087-0090 paras 363-370
22 INQ000474864_0087-0088 para 365, Table 2, Figure 22
23 INQ000474864_0022 para 89; INQ000528391_0004, 0078-0079 paras 11, 289-294
24 INQ000528391_0004, 0078-0079 paras 11, 289-294

4.14. In a pandemic, healthcare equipment supply chains are prone to disruption as a result of demand and price volatility and the globalised and fragmented nature of supply chains. This results in low visibility of inventory and shipments, disruption to international transport networks, and foreign government intervention in the normal functioning of the international market.[25]

4.15. The so-called 'bullwhip effect' occurs when a small change in customer demand leads to increasingly large changes at each subsequent stage of the supply chain (see Figure 10).[26] The Covid-19 pandemic produced an "*extreme version*" of this effect, creating global market dysfunction.[27]

Figure 10: The bullwhip effect



Source: INQ000474864_0022 para 88 Figure 5

International procurement and the China Buy team

4.16. While procurement of PPE from a range of countries was part of the UK government's overall response to the pandemic, its initial efforts were focused on China.[28] This was because manufacturers and distributors there had the capacity to supply healthcare equipment at a significantly larger scale and lower cost than the UK or other countries. This was not least due to the dominance of these suppliers in the PPE market and important pre-existing procurement relationships between the UK government and some suppliers in China. This facilitated quicker access to PPE during the initial stages of the pandemic.[29] Even in January and February 2020, at

25 INQ000474864_0038 para 152
26 INQ000474864_0021 para 86
27 INQ000474864_0021-0022 para 88
28 INQ000528391_0085 para 315
29 INQ000563395_0010-0011 para 44; INQ000474864_0008, 0010, 0017, 0157 paras 31, 43, 72, 698

the height of its own Covid-19 crisis, China increased PPE production capacity; by March 2020, as its economy reopened and other countries imposed export controls on healthcare equipment supplies, it increased PPE output to meet international demand.[30]

4.17. The China Buy team was established in March 2020 to lead the effort for the UK government to procure PPE from China during the Covid-19 pandemic.[31] Although it operated under the authority of the Department of Health and Social Care, China Buy was led by the Foreign and Commonwealth Office and the Department for International Trade, which provided the in-country and international commercial expertise that the Department of Health and Social Care lacked.[32]

4.18. The primary sourcing strategy of China Buy was to place orders with state-owned healthcare equipment distributors that had connections with a wide range of manufacturers in China. According to officials in the China Buy team, the approach had its advantages:

- State-owned distributors had better access to raw materials.
- It spread risk – if any single factory was unable to meet part of the order, other factories in the distributors' network could step in.
- The distributors were experienced in completing the export documentation.[33]

4.19. China Buy had advantages in speed and scale over other sources of supply, including domestically manufactured PPE (discussed below), which allowed for large volumes of PPE to be procured quickly and at generally lower cost to meet the UK's urgent demand.[34]

4.20. However, due to restrictions on movement in China, UK procurement officials were constrained in their ability to quality-assure the healthcare equipment being manufactured. There were some concerns about the quality of PPE procured from suppliers in China: some products did not meet the required specifications or lacked the necessary export documentation.[35] In addition, the procurement of PPE through intermediaries in China increased exposure to "*unreliable production capacity*", as manufacturers might be unable consistently to produce the required quantity of goods on time, and to non-compliance with UK standards.[36] In the absence of better routes of supply of healthcare equipment during the emergency, the UK government had little or no choice but to accept this compromise over control.[37]

30 INQ000477701_0002 para 7
31 INQ000528391_0089 para 329b
32 Andrew Mitchell 10 March 2025 59/16-61/20; INQ000528393_0031-0032 paras 106-107; INQ000528391_0005 para 13
33 INQ000477701_0002 para 5
34 INQ000474864_0017, 0081 paras 72, 335
35 INQ000477701_0002 para 6
36 INQ000477701_0002 para 6; INQ000474864_0157 para 696; INQ000527714_0141 para 13.22
37 INQ000540488_0019 para 3.47c

Developments in supply chain resilience

4.21. At the onset of the pandemic, one of the fundamental weaknesses in the UK's ability to source PPE was the absence of a dedicated body with oversight of supply chain resilience.[38]

4.22. Boris Johnson MP, Prime Minister from July 2019 to September 2022, commissioned Project Defend in April 2020 to investigate vulnerabilities in supply chains, including those for healthcare equipment.[39] In May 2020, as part of Project Defend, Boston Consulting Group (a professional services company) examined the vulnerability of some of the UK's critical supply chains, including for healthcare equipment, for the Department for International Trade. Its report confirmed that the UK was exposed to a high risk of supply chain concentration in healthcare equipment, particularly emanating from China.[40] It recommended that, in the long term, the UK government should mitigate its exposure to such vulnerability through a range of measures – including a cross-government approach involving the Foreign and Commonwealth Office, the Department for International Trade, the Home Office and the Ministry of Defence – focused on international "*coalition-building*" alongside a continual assessment of the geopolitical risk to the UK.[41]

4.23. The benefits of Project Defend for the UK government and devolved administrations included:

- the establishment of a central coordination point in the UK government to increase training, awareness and understanding of the vulnerabilities in supply chains;[42] and
- increased cooperation and coordination with allies around the world to improve supply chain resilience.[43]

4.24. The Economic Security and Supply Chain Resilience Directorate has since been established, effectively making Project Defend a permanent team within the Department for Business and Trade.[44] Its remit is to diversify supply through trade and global sourcing, partner and collaborate with allies, create strategic reserves of critical goods, support infrastructure development and expand the capacity for UK manufacturing.[45] On 17 January 2024, the directorate published the *Critical Imports and Supply Chains Strategy*, which defined critical imports as "*those goods imported into the UK which are critical to the UK security*".[46] There was, however, only a

38 INQ000527714_0048, 0184-0185 paras 4.52, 16.52-16.53
39 INQ000527714_0112 para 11.1
40 INQ000515681_0383, 0385-0393
41 INQ000515681_0394
42 INQ000527714_0132 para 11.89(a)
43 INQ000527714_0133 para 11.89(d)
44 INQ000527714_0134-0135 paras 12.1-12.2
45 INQ000527714_0134-0135 paras 12.1-12.4
46 *Critical Imports and Supply Chains Strategy*, UK Government, January 2024, p7 (https://assets.publishing.service.gov.uk/media/65a6a1c1867cd800135ae971/critical-imports-and-supply-chains-strategy.pdf; INQ000498071)

cursory reference in the strategy to healthcare equipment and no acknowledgement of the concentration of the UK's healthcare equipment supply chains in China and the problems this caused in the earliest stages of the pandemic.[47]

4.25. As set out in the Inquiry's Module 1 Report, a lethal disease represents a threat to national security.[48] The UK government has not yet detailed how it plans to address the identified supply chain weaknesses (eg by diversification) and so this remains an area of vulnerability. Although the Department for Business and Trade has established a new Supply Chain Centre, there is as yet no evidence of an adequate strategy being formulated to make a permanent and structural improvement to healthcare equipment supply chain resilience for a future pandemic.[49]

Domestic industrial resilience

4.26. A key component of the pandemic response of the UK government and devolved administrations was to scale up domestic manufacturing capacities to complement overseas sources of supply.[50]

4.27. However, there were no plans for how the UK government could support UK industry to increase its manufacturing capacity in the event of a pandemic. The earliest proposal by the UK government for the scaling-up of domestic manufacturing of PPE was on 12 March 2020.[51] Procurement was initially focused on offers from established manufacturers and distributors in China and offers from new suppliers in the UK. This meant that UK Make (a joint programme between the Department of Health and Social Care and the Department for Business, Energy and Industrial Strategy to increase the domestic manufacturing of PPE) was not properly established until the appointment of Paul Deighton, Lord Deighton, to lead it in April 2020.[52] There was an approximately six-week delay between the plans being written by the Department of Health and Social Care and their being implemented by it and the Department for Business, Energy and Industrial Strategy. During this time (on 23 March 2020), the UK entered the first lockdown.[53]

47 *Critical Imports and Supply Chains Strategy*, UK Government, January 2024, p27 (https://assets.publishing.service.gov.uk/media/65a6a1c1867cd800135ae971/critical-imports-and-supply-chains-strategy.pdf; INQ000498071)
48 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Introduction and Chapter 1 (https://covid19.public-inquiry.uk/documents/module-1-full-report); INQ000196611_0035 para 88c
49 *The UK's Modern Industrial Strategy*, UK Government, November 2025, p42 (https://assets.publishing.service.gov.uk/media/69256e16367485ea116a56de/industrial_strategy_policy_paper.pdf; INQ000659868); INQ000474864_0059 para 250
50 INQ000528391_0201, 0206-0207 paras 757e, 770-771
51 INQ000528391_0079, 0095 paras 295, 355; INQ000496771
52 INQ000527570_0005 para 2.5; INQ000517443_0066 para 12.10; INQ000528391_0098 para 365
53 INQ000086759_0003

Innovations in manufacturing across the UK

4.28. Lord Deighton told the Inquiry that, by April 2020:

> "*Public confidence in the Government's ability to deal with the problem was waning. Part of the solution was to strengthen* [the Department of Health and Social Care's] *leadership with outside expertise.*"[54]

4.29. The Department of Health and Social Care retained leadership of the procurement process but needed the Department for Business, Energy and Industrial Strategy's connections with industry first to identify domestic manufacturers with the potential to produce PPE at scale and then to support them to retool.[55]

4.30. UK Make had to design a strategy from scratch for the domestic production of PPE, streamline technical guidance, expedite the approval process and expand regional manufacturing.[56] Nonetheless, the first UK Make product was received 25 days after the formation of the team, when five UK manufacturers started delivering aprons.[57] UK-manufactured filtering facepiece respirator class 3 (FFP3) masks were delivered to warehouses for onward distribution to end-users from September 2020.[58] Between 1 December 2020 and 28 February 2021, 82% of demand for PPE was met by UK manufacturers.[59] The vast majority of this new domestic manufacturing capacity was created with government assistance to repurpose existing manufacturers and guide them through the procurement process.[60]

4.31. However, there were no production facilities to manufacture gloves in the UK during the pandemic.[61] This was due to an inability to source the necessary raw materials, the high capital investment requirement and long lead times for manufacture.[62] The UK had to rely on international supplies, competing with other countries in a global market in which prices were rapidly increasing.

4.32. UK Make, as well as the Ventilator Challenge (see below) and NHS Test and Trace, took a number of innovative approaches to the domestic manufacture of healthcare equipment during the pandemic. These innovations included:

- proactive and strategic sourcing of suppliers;
- collaboration between the private and public sectors; and
- efficient management and organisation.

54 INQ000536422_0002 para 7
55 INQ000527570_0005-0006, 0008 paras 2.5, 2.7, 2.14; INQ000517443_0066, 0074-0075 paras 2.10, 12.47-12.49
56 INQ000536422_0005-0007 paras 14-19; INQ000064907_0004 paras 2.3-2.3.4; INQ000517443_0065-0067 paras 12.8-12.13
57 INQ000528391_0098 para 367
58 INQ000528391_0099 para 369
59 INQ000474864_0117 para 496
60 INQ000474864_0117 para 498
61 INQ000474864_0117 para 496
62 INQ000536422_0007 para 19

Proactive and strategic sourcing of suppliers

4.33. Although UK Make initially considered adopting the same approach to offers as taken by the PPE 'call to arms' (see Chapter 2: Emergency procurement and distribution during the pandemic), by May 2020 it had recognised the inherent resource intensiveness in this approach.[63] As it was put in an NHS strategy document in April 2020, UK Make was to "[m]*ove to a wartime process for compliance and bureaucracy*".[64] UK Make took a different, proactive, selective and therefore more strategic approach to key domestic manufacturers that could produce PPE at scale.[65] It sought and selected domestic manufacturers able to produce at scale and was not therefore overwhelmed with triaging offers from unreliable suppliers.[66] Given the scale of the emergency and the inefficiencies in the procurement system examined in Chapter 2: Emergency procurement and distribution during the pandemic, this was the right approach.

Collaboration between the private and public sectors

4.34. UK Make brought in supply chain experts from the private sector, but they often had little experience of working with the government and so the Department for Business, Energy and Industrial Strategy team acted as an important conduit between the various parties.[67] As examined in detail in Chapter 5: Procurement and distribution expertise and experience, this was an effective and collaborative partnership between the private and public sectors during the pandemic. It successfully merged the expertise of both to work as a single team. Crucially, it had a project management office with "*teeth*" to escalate and unblock issues.[68]

4.35. The domestic manufacturers identified to produce PPE as part of UK Make were selected according to their experience and ability to make what was needed at sufficient scale and to the correct technical specifications.[69] They primarily needed government support with access to the routes of supply for raw materials, detailed product specifications and navigating the Department of Health and Social Care procurement process (see Chapter 2: Emergency procurement and distribution during the pandemic).[70] Some were manufacturers of products similar to PPE and used similar materials or processes that could move from one product to another – for example, plastic bags to aprons, pilot overalls to gowns, or ski goggles to eye protection.[71]

63 INQ000517443_0076 para 12.55; INQ000536422_0008 para 20; Paul Deighton 18 March 2025 69/19-71/3; Tim Jarvis 12 March 2025 12/21-15/7
64 INQ000513154_0001-0002
65 INQ000536422_0005-0006 para 17; INQ000517443_0075 para 12.51; INQ000475379_0002
66 INQ000513154_0001-0002
67 INQ000536422_0002 paras 6-7; INQ000527570_0007 para 2.10
68 INQ000513154_0001-0002
69 INQ000536422_0007 para 19; INQ000517443_0075 para 12.51; INQ000475379_0002
70 INQ000536422_0007 para 19
71 INQ000536422_0007 para 19

4.36. UK Make took the domestic production of PPE from a standing start to a substantial contribution to the pandemic response. Assisted by officials, UK manufacturers stepped up to the challenge and were a vital source of PPE supplies. Dame Emily Lawson, Chief Operating Officer (Interim) at NHS England from November 2023 to March 2025, told the Inquiry that UK Make was an unexpected success. It had not been thought that domestic manufacturing could scale up its capacity so rapidly.[72] By July 2020, UK manufacturing capacity as a percentage of expected UK demand for PPE was 30% and by December 2020 it had reached 70% (see Figure 11).[73] Although this was in line with Mr Johnson's stated objective, it was only reached some time after the height of the procurement crisis.[74]

Figure 11: UK PPE manufacturing capacity as a percentage of expected UK demand, April to December 2020

Source: INQ000551751_0026 Figure 10

4.37. With better planning and preparation, there could have been earlier reliance on the UK's manufacturing sector. Based on the plans to scale up domestic manufacturing that were created during the pandemic but not immediately acted upon by the Department of Health and Social Care, domestic manufacturing could have been started earlier – by as much as six weeks.[75] This was a critical period, in which the UK could have had, with adequate planning and foresight, a head start in increasing its domestic manufacturing capabilities and would not have needed to rely so heavily on overseas suppliers.

Efficient management and organisation

4.38. Recognising the complexity of the Department of Health and Social Care procurement process, Lord Deighton structured first the UK Make team, and subsequently the entire PPE Cell, so that one team could guide a manufacturer through all eight steps to approval (see Chapter 2: Emergency procurement and distribution during the pandemic).[76] UK Make was organised into six teams by

72 Emily Lawson 11 March 2025 65/5-8
73 INQ000528391_0206-0207 para 771, Figure 15
74 INQ000528391_0206-0207 paras 770-771
75 INQ000528391_0079 para 295; INQ000517443_0066 para 12.10
76 INQ000536422_0022 para 67

product category, which meant that each team obtained a deep understanding of its area of specialisation.[77] The leader of each team was responsible for taking potential contracts through the Department of Health and Social Care procurement process.[78] This meant that potential suppliers could be identified and matched to demand, and there was a single point of accountability and point of contact for manufacturers that were new to the process.[79]

4.39. The specialist category teams also worked in 'sprints' in which there was a set, dedicated timeframe of a week in which work had to be completed.[80] Their objective was to find the right suppliers and design the supply chain within the extremely short timescales demanded by the scale of the emergency.[81] The organisation and management of UK Make resulted in a fast, streamlined and efficient system for the domestic manufacturing and procurement of PPE.

Domestic manufacturing in the devolved administrations

4.40. During the pandemic, each of the devolved administrations built PPE supply capacity in its respective domestic manufacturing base.

4.41. In Scotland, a new PPE supply chain was built "*from scratch*".[82] The Directorate for Economic Development, Scottish Enterprise and the National Manufacturing Institute Scotland collaborated to work with domestic manufacturers to redirect or expand the production of products such as gowns, plastic aprons and medical grade face masks.[83]

4.42. Of 96 new PPE contracts awarded by NHS National Services Scotland during the pandemic, all of which were successfully delivered, three contracts went to new Scottish suppliers as a result of Scotland's domestic 'make' initiatives.[84] By April 2021, approximately 88% of Scotland's PPE (by value, excluding non-sterile examination gloves) was domestically manufactured.[85] But the investment of £102.7 million in Scottish suppliers resulted in £66.7 million of additional gross value added (the value generated in the production of goods and services) and supported 1,400 jobs, with an estimated eight-to-one multiplier effect for local spending.[86] The Scottish Government acknowledged, however, that post-pandemic demand has not been sufficient to sustain all the local PPE suppliers.

77 INQ000536422_0005-0006 paras 16-17
78 INQ000536422_0005-0006 para 17
79 INQ000536422_0007 para 19
80 INQ000517443_0075 para 12.51
81 INQ000517443_0075 para 12.51
82 INQ000498141_0062 para 198
83 INQ000502043_0010-0011 paras 26, 28-30; INQ000521969_0046 para 180
84 INQ000521969_0047 para 182
85 INQ000108737_0019 para 43; INQ000521969_0046 para 180; Gordon Beattie 24 March 2025 101/5-8
86 INQ000481269_0002 para 5; INQ000502570_0010

4.43. In Wales, a greater proportion of the Welsh economy is given over to manufacturing than in the UK as a whole.[87] During the pandemic, existing domestic manufacturers increased production, while others switched to making items required for the pandemic response. This expansion created an estimated 400 jobs.[88] The Critical Equipment Requirement Engineering Team was established, initially to support the Ventilator Challenge and later becoming an important part of both triaging PPE supply offers and stimulating Wales-based manufacture of PPE and related items.[89] A call to action issued to Welsh businesses in April 2020 resulted in efforts like securing fabric for scrubs (clothing worn by healthcare workers) and working with a network of businesses and social enterprises – between April and May 2020, Wales was approaching self-sufficiency in scrubs.[90]

4.44. Despite these significant efforts, however, it took an "*extensive*" amount of time for Welsh PPE manufacturers to produce suitably certified PPE.[91] By the time this had been achieved, stocks had already been secured from alternative suppliers.[92] A 'lessons learned' exercise by the Welsh Government in January 2021 noted that it took time to engage Welsh manufacturers and expressed concerns about the high cost of Welsh-manufactured PPE.[93]

4.45. The Department of Health (Northern Ireland) aimed to repurpose Northern Ireland's manufacturing industry for PPE production.[94] The Northern Ireland Executive Office made an open call to PPE manufacturers and Invest Northern Ireland proactively to identify suitable companies.[95]

4.46. Seven contracts worth an estimated £165.8 million were awarded to local businesses, playing an important role in stabilising Northern Ireland's PPE supply.[96] Local manufacturing offered advantages such as better management of delivery schedules, warehouse space and product lifespan. It also ensured a reliable supply of consistent models of certain PPE, as demonstrated by a collaboration with Denroy (a local designer and manufacturer of polymer components) to develop and approve a new FFP3 mask design which reduced the need for repeated fit-testing.[97]

87 INQ000528293_0021 para 88
88 INQ000506956_0057 para 238
89 INQ000321202; INQ000527722_0007 paras 23-25
90 'First Minister's call to action for business: Help us provide PPE to frontline NHS staff', Welsh Government, 3 April 2020 (https://www.gov.wales/first-ministers-call-action-business-help-us-provide-ppe-frontline-nhs-staff; INQ000505374); 'Economy Minister praises businesses helping coronavirus fight', Welsh Government, 8 April 2020 (https://www.gov.wales/economy-minister-praises-businesses-helping-coronavirus-fight; INQ000477058); INQ000528293_0026-0029
91 INQ000536425_0031 para 127
92 INQ000536425_0031 para 127
93 INQ000472023_0003
94 INQ000521964_0083 para 278
95 INQ000534957_0007 para 26
96 *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers*, Northern Ireland Audit Office, 1 March 2022, p64 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882)
97 INQ000536161_0019-0020 para 84

4.47. Each of the devolved administrations was clear about the benefits of its domestic manufacturing efforts. Conor Murphy MLA, Minister for Finance in Northern Ireland from January 2020 to October 2022, observed that the benefits of local manufacturing were environmental, economic and greater supply chain resilience.[98] Jeane Freeman MSP, Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021, told the Inquiry that creating a domestic PPE supply chain was "*a protection against future global challenge*".[99] Mark Drakeford MS, First Minister of Wales from December 2018 to March 2024, urged:

> "*Wales and the UK must ensure that we have a robust indigenous supply with on-shore capacity to produce the equipment we will need.*"[100]

With better preparation and investment, domestic manufacturing in the devolved nations could play a valuable role in the resilience of the UK's PPE supply in the future.

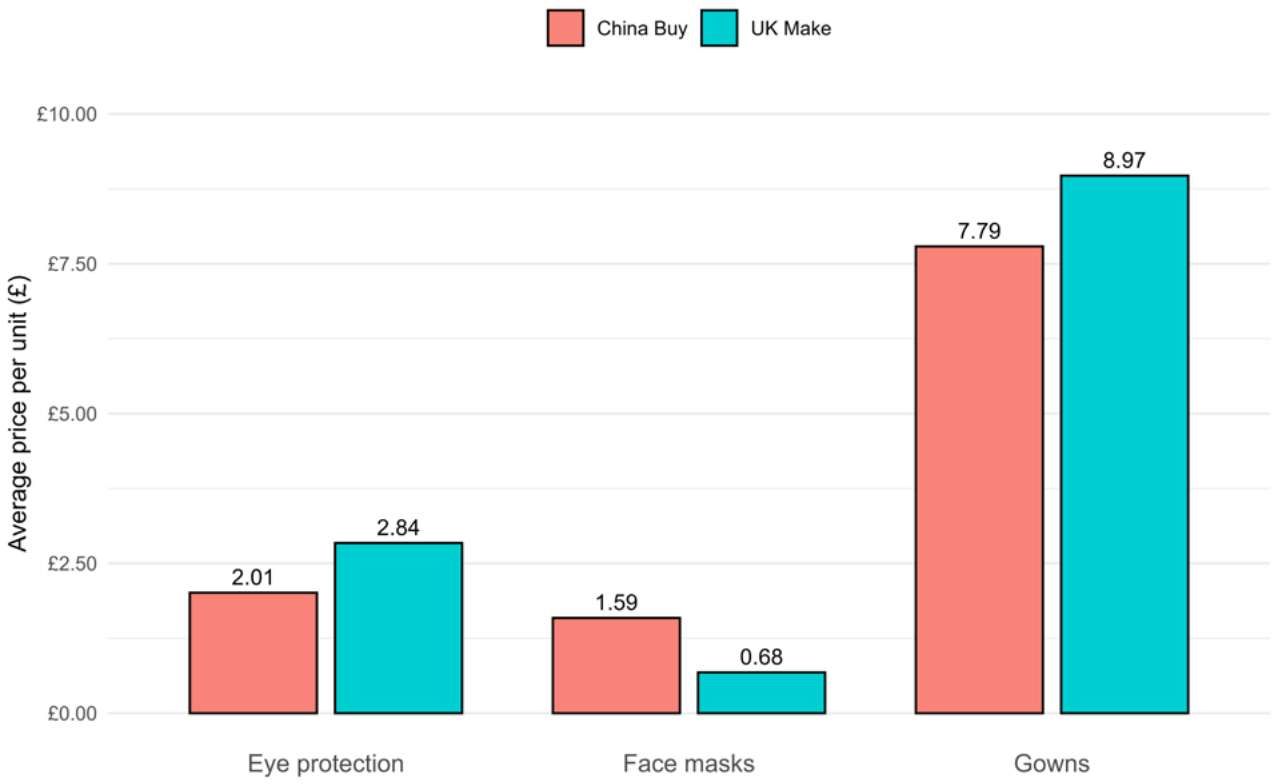
Manufacturing PPE in the UK and China

4.48. Although it is difficult to draw exact comparisons, based on the data provided by the Department of Health and Social Care, the Inquiry's analysis indicates:

- There were fewer issues in contractual performance (examined in detail in Chapter 6: Transparency, governance and accountability) with UK Make contracts (29%) compared with China Buy contracts (56%).[101]
- The average prices per unit in single-item contracts were lower in China Buy for gowns and eye protection (by £1.18 and £0.83 respectively) but higher for face masks (by £0.91).[102]

98 Conor Murphy 26 March 2025 120/10-16
99 Jeane Freeman 24 March 2025 29/16-20
100 INQ000528293_0020 para 84
101 INQ000660160_0002 Table 2
102 INQ000660160_0003 Table 3

Figure 12: Average unit cost of selected PPE items by China Buy and UK Make workstreams



Source: INQ000660160_0003 Table 3. The analysis only considers 262 contracts for single types of PPE, using their original contract values and agreed quantities. The Inquiry did not include 24 contracts that covered more than one type of PPE. The results could be affected by differences in the specification of items, extra costs (eg transportation, administration or insurance), how prices were set, the type of contract and changes in the market over time. All these things can make it hard to compare contracts fairly.

4.49. UK Make demonstrated that, with greater input and control over the manufacturing and distribution of PPE, there were advantages of supply chain resilience and contractual performance in an emergency – but, as Lord Deighton observed:

> "*We simply cannot be competitive with countries like China in producing these kinds of high-volume, low-value items as are typical for PPE.*"[103]

4.50. John Manners-Bell, expert witness on supply chains, told the Inquiry that it was likely that the majority of those businesses that pivoted to the manufacture of PPE and other healthcare equipment during the pandemic had subsequently returned to their former lines of business.[104] One executive of a company that moved to PPE production during the pandemic reported:

> "*The landscape of procurement has returned to pre-Covid practices and it's clear that lessons haven't been learnt. This puts domestic capability at serious risk of vanishing.*"[105]

103 INQ000536422_0009-0010 para 26
104 INQ000474864_0119 para 501
105 INQ000474864_0119 para 502

4.51. Without government incentives, or increasing levels of automation reducing the need for a low-cost labour force, long-term, large-scale domestic healthcare equipment production in the UK will be difficult to achieve.[106] The UK government and devolved administrations need to invest in the UK's advanced manufacturing base for assets of strategic national importance such as healthcare equipment.

The UK's leadership in advanced manufacturing

4.52. The UK government's approach to the domestic design and manufacture of testing equipment and ventilators involved bringing together leading figures from the health, life sciences and manufacturing sectors and developing innovative ways of working between government and industry. The public and private sectors were required to work together to find novel solutions to complex problems and thus engineer their way out of the procurement crisis.

Testing equipment

4.53. The UK government's mass testing programme for Covid-19 arose from its close collaboration with industry and academia. Before the pandemic, the UK government had limited engagement with the diagnostics industry, and the lack of a body with either the mandate or the capacity to scale up mass testing put it at a disadvantage (see Chapter 1: The UK's readiness for emergency procurement and distribution).

4.54. The polymerase chain reaction (PCR) test, initially the only test for Covid-19 available, had certain limitations for mass deployment and, exacerbated by lockdowns and export controls, global demand for PCR tests outstripped supply.[107] As Dr Beverley Jandziol (Commercial Specialist in the Complex Transactions Team at the Cabinet Office from September 2019 to May 2022, deployed to the Department of Health and Social Care's Covid-19 National Testing Programme, which became NHS Test and Trace, from March to December 2020) told the Inquiry, the UK was "*too reliant*" on large international suppliers, the domestic life sciences industry of small and medium-sized enterprises had been "*neglected*" and the UK was "*vulnerable*" to US export controls.[108]

4.55. Domestic production of PCR testing equipment increased, with major companies rapidly expanding their operations.[109] The testing programme focused on the UK's domestic diagnostics capacity to find faster testing methods.[110] It was only following the World Health Organization's approval of lateral flow tests in the autumn of 2020 that NHS Test and Trace established a domestic manufacturing programme for testing equipment, aiming for the production of more than 2 million per day.[111]

106 INQ000474864_0008 para 29
107 INQ000562340_0044-0045 para 103
108 INQ000562340_0066 para 160
109 INQ000562340_0028 para 53
110 INQ000237333_0004, 0013
111 INQ000521972_0047, 0052 paras 4.135-4.136, 4.159

While PCR tests remained the gold standard due to their higher sensitivity, lateral flow tests were suitable for rapid home use, enabling mass asymptomatic testing.[112] By February 2021, 15 million lateral flow tests were deployed weekly and NHS Test and Trace began to scale down PCR testing, due not only to increased lateral flow device use but also to the rollout of the vaccine programme.[113]

4.56. James Bethell, Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021), told the Inquiry that industrialising the UK's domestic testing capacity required an increase in domestic manufacturing using the licences of other overseas companies. If the UK is to build sovereign manufacturing capabilities, domestic investment in diagnostic capacity and capability is essential.[114]

4.57. In the early stages of the pandemic, while the testing technology was still developing, the UK government did not yet know what types of testing equipment and manufacturing capacity were needed. Engagement with industry "*brought up fresh and new ideas, some of which were not conventionally used by the system*", of which lateral flow tests were just one example.[115] Lord Bethell, Dr Jandziol and Sarah Collins (Commercial Director at the UK Health Security Agency from January 2022 to January 2025) stressed the importance of continued engagement with industry to identify solutions to the novel scientific and manufacturing problems posed by pandemics.[116]

4.58. After the Covid-19 pandemic, the UK Health Security Agency established a diagnostics accelerator programme, working with industry to develop and approve new diagnostic technologies for emerging threats.[117] The programme aims rapidly to evaluate and validate diagnostics for pathogens that may cause pandemics in the future.[118] This vital programme should be maintained in the long term and ensure that the UK government maintains direct connections to the domestic diagnostic industry and academia.

Ventilators

Recognising the need for domestic production

4.59. The procurement of ventilators and other complex and high-value medical technology presents very different challenges from the procurement of PPE. Production is highly technical, supply chains are very specialised and quality control is essential.[119] The purchase of ventilators for the NHS typically involved: an extended

112 INQ000521972_0051-0052 para 4.155
113 INQ000521972_0054 para 4.170
114 INQ000528392_0012 para 35; INQ000497128 para 3(i)
115 James Bethell 19 March 2025 14/17-15/2
116 James Bethell 19 March 2025 14/10-15/2; Sarah Collins 13 March 2025 79/14-22; Beverley Jandziol 13 March 2025 140/14-25
117 Sarah Collins 13 March 2025 108/12-23
118 INQ000521972_0086 para 8.23.2
119 INQ000474864_0082, 0167-0168 paras 339, 7

procurement process with long lead times; physically testing sample machines provided by suppliers for evaluation; contracting with suppliers for the provision of non-generic consumables and long-term support and maintenance; and training and familiarisation processes, both for healthcare staff and clinical engineering teams within the NHS.[120]

4.60. At the start of the pandemic, there were no large-scale domestic producers of intensive care unit mechanical ventilators or domestic companies with current lines of intensive care unit mechanical ventilators licensed for sale in the UK.[121] The majority of ventilators and PPE were, and continue to be, manufactured in East Asia, in particular China and Malaysia.[122] In early 2020, the Chinese government introduced restrictions on exports, including ventilators.[123] This resulted in acute challenges to normal procurement channels in the UK, exacerbated by increased international demand, fierce competition in the global marketplace and some countries offering above market prices to secure products.[124]

4.61. As part of the Department of Health and Social Care and NHS England's Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme (described in Chapter 2: Emergency procurement and distribution during the pandemic), one strategy for securing more ventilators for the NHS was the establishment of a joint unit between the Department of Health and Social Care, the Foreign and Commonwealth Office and the Department for International Trade to secure overseas opportunities for the purchase of as many ventilators as possible from global suppliers.[125] The level of global competition, however, made this difficult. According to the Department for International Trade:

> "*Speculators, opportunistic intermediaries and individuals had piled in, trading up prices exponentially … We had entered a ventilator procurement 'Wild West'.*"[126]

4.62. At the end of March 2020, credible offers of ventilators from overseas were being made at high and rising prices, with the unit price sometimes doubling within a day.[127] Given the anticipated shortfall of ventilators in the UK in April 2020, the Department of Health and Social Care concluded that, despite the price being two to three times above the average pre-pandemic price range, it had no option but to buy them.[128]

4.63. The quality of ventilators and associated equipment procured from overseas – and their suitability for use in the NHS – was variable. Professor Ramani Moonesinghe, National Clinical Director for Critical and Perioperative Care at NHS England from March 2020, led a team reviewing lists of devices already on the NHS procurement

120 INQ000561670_0014 para 58
121 INQ000497031_0066 para 4.9.2
122 INQ000569123_0010, 0024 paras 4.4, 4.62-4.63; INQ000563395_0010-0011 para 44
123 INQ000474864_0011 para 46
124 INQ000493942_0001
125 INQ000497031_0065-0066 para 4.9.1
126 INQ000493942_0001
127 INQ000496599_0002
128 INQ000513708_0035 para 146

framework, as well as device lists provided by the Department of Health and Social Care through its engagement with sales teams internationally. The aim was to provide a clinical review of the suitability of the devices on these lists for use in the pandemic and provide a "*go/no-go*" recommendation to the Department of Health and Social Care commercial team on whether to procure.[129] However, the information upon which Professor Moonesinghe and her colleagues based their advice on which ventilators to buy during the pandemic usually came only from open sources, such as suppliers' or manufacturers' marketing materials. This was because, as she explained, "[W]e *had to make rapid procurement decisions because of the high international demand.*"[130] There was no time to undertake proper clinical reviews.

4.64. This had important ramifications for front-line clinicians, who had concerns about the safety of using unfamiliar devices, a lack of appropriate consumables and a lack of competency training for clinical teams in the ventilators and other equipment procured in the pandemic.[131] Ashley Shaw, Medical Director at Cambridge University Hospitals NHS Foundation Trust, told the Inquiry:

> "*Many teams had to take the minimal training materials and train themselves in the specific nuances of the devices, based on previous experiences. In addition, many of the devices and consumables came from China, and the instructions for use and associated documentation was accordingly in Chinese.*"[132]

4.65. The Shangri-La 510S ventilator, manufactured by Beijing Aeonmed, was the first model procured by the Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme.[133] Despite being a transport ventilator (primarily for use when transporting patients, such as in ambulances), its specifications were deemed acceptable by the Department of Health and Social Care due to its low cost, apparent regulatory compliance and rapid availability from reputable suppliers.[134]

4.66. These ventilators, however, raised significant concerns. Toby Lewis, Chief Executive of the Sandwell and West Birmingham Hospitals NHS Trust until 2021, said that a delivery on 6 April 2020 was "*unusable as supplied*", with insufficient consumables and no information on their future supply.[135] Dr Jon Hulme, Consultant in Intensive Care Medicine and Anaesthesia at the same trust, warned that using these ventilators could lead to "*significant patient harm, including death*".[136] Professor Tom Clutton-Brock, Professor of Anaesthesia and Intensive Care Medicine at the University of Birmingham and Director of the Medical Devices Testing and Evaluation Centre (which conducted independent testing of ventilators during the pandemic), concluded that the device was "*unsuitable as a substitute for a critical care ventilator in all but extreme circumstances*", recommending:

129 INQ000518349_0018 para 60
130 INQ000518349_0018 para 60
131 INQ000512921_0008 para 6.6
132 INQ000536367_0006 para 28
133 Chris Stirling 17 March 2025 32/23-33/2, 35/4-12
134 INQ000561670_0026 para 130
135 INQ000520831_0004-0005 paras 11, 14
136 INQ000508296_0001

> "*Even in pandemic times rapid external review of new technology procured for the NHS should be undertaken to identify suitability and training needs.*"[137]

This training need must be taken into account in future emergency procurement of medical technology.

4.67. The Department of Health and Social Care acknowledged concerns about the quality of these ventilators.[138] Having arrived in late March 2020, the devices were taken out of service on 19 April 2020 and a refund was negotiated with the manufacturer for 70% of the purchase price – a loss of approximately £1.2 million.[139] The department also recognised that issues with new devices were better managed centrally, rather than distributing the devices to trusts to work through issues individually (as had happened in the early stages of the Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme). Training materials available to clinicians and front-line healthcare workers improved over time, largely due to feedback from trusts.[140] Greater involvement of clinicians at an earlier stage of the procurement process in advance of a future emergency could minimise the likelihood of these issues happening again.[141]

The Ventilator Challenge

4.68. At the same time, in March and April 2020, the Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme's domestic 'make' drive – which became known as the Ventilator Challenge – worked with suppliers and manufacturers based in the UK to increase the domestic production of ventilators.[142] The Ventilator Challenge was run by the Cabinet Office Complex Transactions Team, which had staff with significant commercial experience and expertise.[143]

4.69. The two approaches taken to meeting the Ventilator Challenge were:

- identifying and then increasing the production of existing ventilator designs, adapting these where necessary; and
- developing new designs for ventilators that could be manufactured quickly and that did not require components that might overlap and compete with each other or with existing ventilator designs.[144]

137 INQ000514240_0009
138 INQ000561670_0026 para 132
139 INQ000518349_0025-0026 para 94; INQ000514215_0001; INQ000514275
140 Chris Stirling 17 March 2025 28/3-5
141 Rosemary Gallagher 18 March 2025 44/21-45/19
142 INQ000497031_0066 para 4.9.2
143 INQ000497031_0066 para 4.10
144 INQ000497031_0066 para 4.11.2

The Cabinet Office's target was to make 30,000 ventilators in eight weeks by the end of April 2020, based on the predicted worst-case scenario. The programme "*sought to pursue all realistic alternative routes to achieve this goal*".[145]

4.70. A Technical Design Authority was to make recommendations on proposed suppliers' ventilator designs to ministers, based on clinical observations.[146] Alongside senior representatives of the Cabinet Office, the Technical Design Authority included the Medicines and Healthcare products Regulatory Agency for regulatory oversight; senior clinicians led by Professor Moonesinghe for clinical sign-off on proposed ventilators to be procured; and Professor Clutton-Brock, who reported on the medical testing of all proposed ventilators.[147] Given the speed at which decisions needed to be made, this was a sensible system for maintaining clinical and regulatory oversight.

4.71. Manufacturers worked to a 'Rapidly Manufactured Ventilator Specification'. This was produced by Professor Moonesinghe and her husband (an experienced engineer) within one working day on 13 March 2020 – because, as Professor Moonesinghe told the Inquiry, there was insufficient time to source expertise through wider consultation.[148] This specification was subsequently adapted and refined during the pandemic in collaboration with the Medicines and Healthcare products Regulatory Agency, as clinical understanding of Covid-19 increased.[149]

4.72. In order to scale up production, ventilator designers were matched with companies from outside the medical technology industry which had experience and expertise in manufacturing high-quality products at scale. A successful example of this collaborative approach was a consortium involving the small-scale ventilator supplier Penlon, supported by Ford, McLaren, Siemens, Airbus and other companies that could manufacture at scale and had existing robust quality control procedures in place. This consortium was issued with a production contract on 26 March 2020 – within 13 days of the inception of the Ventilator Challenge on 13 March 2020.[150]

4.73. This rapid work between government and industry was not always smooth, as might be expected under the pressure of a pandemic. Another consortium involving Smiths Medical expressed serious initial concerns. Julian Fagge, Chief Financial Officer of Smiths Group, described what he saw as onerous indemnity terms proposed by the Cabinet Office and exposure to "*fundamentally unreasonable*" and excessive liability – especially where Smiths Medical, a small but established ventilator manufacturer, would be working with third parties with no prior experience in the manufacture of ventilators or other medical devices.[151] The extensive negotiation it took to resolve these issues created hesitation and uncertainty within the consortium, leading to

145 INQ000497031_0068 paras 4.21-4.22
146 INQ000497031_0073-0074 para 4.42.2
147 INQ000497031_0073 para 4.44
148 INQ000518349_0011 paras 35-37
149 INQ000518349_0013 para 40
150 INQ000497031_0019, 0076-0077, 0092 paras 1.55.2, 4.49, 4.51.1, 4.51.4, 4.116.1
151 INQ000513774_0009, 0012 paras 37, 48

delays in commitment from consortium members.[152] In the event that government and industry are required to work in partnership like this in a future emergency, clearer contractual agreements and commitments should be made as far in advance as possible.[153]

4.74. Three companies were awarded a total of five contracts for the supply of ventilators.[154] Four other suppliers developed prototypes that were deemed clinically viable but did not receive contracts, because, by June 2020, the demand for ventilators in the NHS was lower than initially predicted.[155] The extent of the activity required for ventilator procurement – particularly sourcing from overseas suppliers – therefore reduced accordingly.[156]

4.75. By July 2020, more than 15,000 ventilators, which would typically have taken about four and a half years to produce, were made available to the NHS – which, by then, was sufficient to meet the projected NHS demand.[157] Companies involved attributed this success to an extraordinary level of collaboration, innovation and effort.[158] Millions of components were sourced, purchased and shipped from suppliers across the world, in direct competition with other countries facing similar challenges, within very short timescales. Testing equipment was built and quality-assured. Manufacturing space used for non-medical industries, including automotive and aeronautical engineering, was converted for new production lines building ventilators. Training was devised and implemented for hundreds of people staffing those new manufacturing lines.[159] According to UK Research and Innovation, the contribution of wider UK industry in supporting and accelerating the Ventilator Challenge demonstrated that the UK's strong engineering skills base, a sector estimated to generate £645 billion gross value added for the UK's economy annually (equivalent to 32% of the country's economic output), could be flexibly applied to a pandemic response.[160] This capacity should be harnessed in advance of any future pandemic.

4.76. Professor Moonesinghe acknowledged that the efforts made by the Department of Health and Social Care, the Cabinet Office and NHS England were, in many ways, "*remarkable and effective*".[161] However, in relation to the Ventilator Challenge and wider procurement, she concluded:

> "*I do not consider that there was a robust system in place to ensure an adequate supply of key healthcare equipment and supplies to the NHS during the initial phase of the pandemic.*"[162]

152 INQ000513774_0009, 0012-0013 paras 36-37, 48, 52-53; INQ000504077
153 INQ000513774_0032 para 132
154 INQ000497031_0092-0093 para 4.116
155 INQ000497031_0097 para 4.132; INQ000572261_0023 para 106
156 INQ000572261_0008 para 35
157 INQ000497031_0019 para 1.55.2; INQ000541374_0038 para 136
158 INQ000513774_0002 para 6
159 INQ000513774_0007-0008 para 33
160 INQ000539151_0020-0021, 0025-0026, 0030 paras 54-54.3, 74, 91
161 INQ000518349_0047 para 187
162 INQ000518349_0047 para 187

Research and development into reusable PPE

4.77. The PPE sector traditionally uses linear supply chains in which equipment is discarded after a single use.[163] Circular supply chains involve manufacturing, using, cleaning and then reusing or recycling healthcare equipment. Before the pandemic, items like surgical gowns, drapes and scrubs were used, laundered and reused across the NHS – about 20% of surgical gowns and drapes were reusable.[164] The Department of Health and Social Care established a Reuse, Innovation and Sustainability Team with the aim of increasing the use of reusable PPE products.[165] This, however, did not lead to the PPE Cell buying reusable PPE during the pandemic.

4.78. In April 2020, the Textile Services Association (the trade association for the textile care services industry) offered to scale up reusable gown and sterile laundry services during the pandemic, engaging with UK Make and Cabinet Office procurement officials. UK Make staff, Cabinet Office staff and consultants from Deloitte (a professional services company) working to source PPE asked the Textile Services Association to design a reusable gown. The Textile Services Association was in contact with officials from UK Make and the Department for Business, Energy and Industrial Strategy between April and September 2020 and with NHS England between February and August 2021.[166]

4.79. Although the Textile Services Association had repeated contact with officials, including from UK Make and the Cabinet Office Complex Transactions Team – and work was undertaken to reserve raw materials and manufacturing capacity and to ensure compliance with regulatory and technical standards – it did not lead to any contracts.[167] While it explored the possibility of reusable PPE, the UK government prioritised the purchase and manufacture of single-use PPE during the pandemic.[168] This was despite the full supply chain for reusable gowns, including a laundry network, already existing in the UK.[169]

4.80. In April 2020, in response to acute PPE shortages, Public Health England issued guidance allowing for sessional use (ie using an item of PPE for a specific shift, rather than for a specific task or patient interaction, as would be the norm) – and, in extreme cases, reuse – of single-use PPE.[170] This guidance was withdrawn in September 2020, by which time supplies had stabilised.[171] The fact that Public Health England considered the reuse of PPE that was never designed for more than one session of wear necessary during the pandemic suggests that integrating reusable PPE could form an important part of future pandemic preparedness and response.

163 INQ000474864_0053 para 218
164 INQ000513191_0005-0006 paras 21-22
165 INQ000528391_0207-0208 paras 772-774
166 INQ000513191_0008-0011, 0014 paras 34-50, 59; INQ000492362
167 INQ000513191_0011 para 49
168 INQ000513191_0009 para 37
169 INQ000513191_0017 para 73
170 INQ000528391_0063, 0085 paras 231, 316
171 INQ000571763_0030-0031 para 109; INQ000106357

4.81. Reusable PPE provides resilience because it reduces the risk posed by shortages. In addition, the Health and Safety Executive has noted that reusable respirators do not require repeated fit-testing.[172] A report prepared by the Health and Safety Executive at the request of the Scientific Advisory Group for Emergencies (SAGE) also observed that reusable gowns were already being used in health and social care settings and that services to reuse PPE – for example by laundering – were available.[173] Better planning, preparation and investment in research and development for reusable PPE are crucial for future pandemics, promoting domestic resilience, reducing cost and minimising waste.[174] The UK government should incentivise investment in research and development into reusable forms of PPE. This should involve trialling the use of not just new materials but also innovative cleaning technologies.[175]

Blueprints for critical care medical technology

4.82. Despite the adaptability and commitment shown during the Covid-19 pandemic, the level of intricacy involved in the development of complex medical technology, such as ventilators, meant that it was difficult for UK businesses already involved in their production to scale up production.[176] Mr Manners-Bell commented that the help of large manufacturers may well have been better focused on sourcing specialised components for existing ventilator manufacturers rather than trying to build their own versions from scratch, as they did in the Ventilator Challenge.[177] Professor Moonesinghe recommended that, in advance of any future emergency, a panel of experts, including engineers and clinicians, should be commissioned to develop a set of minimum acceptable specifications or blueprints (ie technical designs for manufacturers) for a range of emergency or pandemic scenarios based on the demand and timeframe for the manufacture of particular equipment.[178] The Inquiry agrees.

4.83. The UK has a broad and relatively well-connected medical technology and medical manufacturing, services and supply innovation ecosystem. This gives the UK a comparative global advantage in development, adoption and diffusion of innovation, which can combine quickly and effectively to help the UK's response in crises.[179] The UK government should seek to ensure that these advantages are embedded in its future emergency response plans, with blueprints for rapidly scalable critical care medical technology a focus of its work for future emergencies.

172 INQ000560897_0081 para 306
173 INQ000560897_0082-0083 para 310; INQ000075024_0003-0004
174 INQ000474864_0053 paras 217-219
175 INQ000474864_0054 Author recommendation 5
176 INQ000474864_0082 para 339; INQ000541374_0045 para 162
177 INQ000474864_0116 para 495
178 INQ000518349_0050-0051 para 200c
179 INQ000539151_0030 para 92

4.84. Having such blueprints in place in advance of a future pandemic would improve the feasibility and effectiveness of the UK's response to a significant surge in demand for complex medical technology such as ventilators for the following reasons:

- Regulators (such as the Medicines and Healthcare products Regulatory Agency) could satisfy themselves in advance of the emergency that the proposed specifications were appropriate for different scenarios.
- Clinical professionals, such as doctors and nurses, would have increased confidence in the process for developing and delivering these products.
- Key components that would be difficult to source in an emergency and may therefore constrain production could be procured and stored.
- Contractual arrangements could be reached with UK-based manufacturers which would enable production to begin according to a pre-specified protocol, with liability and indemnity terms negotiated as far as possible in advance.
- It would be possible to plan for training healthcare workers on unfamiliar devices and for a safer expansion of the workforce required to care for high-risk or critically ill patients.
- The financial investment required to deliver these plans would be focused and likely lower than the less targeted approach that the Ventilator Challenge was required to take.

Recommendation 6: Blueprints for critical care medical technology

The UK government and devolved administrations should jointly commission a group of experts to develop blueprints for rapidly scalable critical care medical technology, aligned with the range and severity of pandemic risks identified in the National Security Risk Assessment, within 12 months of the publication of this Report.

The blueprints should be issued in accordance with the emergency healthcare equipment regulations and buyer's guide (see Recommendation 4 of this Report) and regularly reviewed to ensure that they reflect technological advances.

Developments in international trade, supply chain and domestic industrial resilience

4.85. Following the Covid-19 pandemic, the key developments in international trade, supply chain and domestic industrial resilience are set out in:

- the World Health Organization's *WHO Pandemic Agreement* (May 2025);[180]
- *The UK's Trade Strategy* (June 2025);[181]
- *The UK's Modern Industrial Strategy* (June 2025);[182]
- *The UK's Modern Industrial Strategy: Advanced Manufacturing Sector Plan* (June 2025);[183] and
- *The UK's Modern Industrial Strategy: Life Sciences Sector Plan* (July 2025).[184]

4.86. The aim of the *WHO Pandemic Agreement* is to improve international collaboration on pandemic preparedness and response, including the procurement and distribution of healthcare equipment.[185] It commits Member States in a pandemic to cooperating in: the sharing of healthcare equipment, reducing barriers to international trade, promoting supply chain transparency and aligning standards.[186] It aspires to limit protectionism and promote openness in the event of a future pandemic. Although these are welcome developments, the UK should also continue to focus on its national resilience by building on focused trading relationships, such as collaboration between the UK and other countries in the 'Five Eyes' intelligence alliance (comprising the UK, the USA, Canada, Australia and New Zealand), as happened in 2021, to improve its emergency international trade capability and supply chain resilience.[187]

4.87. *The UK's Modern Industrial Strategy* and the related *Advanced Manufacturing Sector Plan* and *Life Sciences Sector Plan* address the UK government's approach

180 *WHO Pandemic Agreement*, World Health Organization, 20 May 2025 (https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf)
181 *The UK's Trade Strategy*, UK Government, June 2025 (https://www.gov.uk/government/publications/uk-trade-strategy; INQ000659800)
182 *The UK's Modern Industrial Strategy*, UK Government, June 2025 (https://webarchive.nationalarchives.gov.uk/ukgwa/20250623151801/https://www.gov.uk/government/publications/industrial-strategy; INQ000659798)
183 *The UK's Modern Industrial Strategy: Advanced Manufacturing Sector Plan*, UK Government, June 2025 (https://assets.publishing.service.gov.uk/media/68920a3366bdd4490c61098f/industrial_strategy_advanced_manufacturing_sector_plan_accessible.pdf; INQ000659802)
184 *The UK's Modern Industrial Strategy: Life Sciences Sector Plan*, UK Government, July 2025 (https://www.gov.uk/government/publications/life-sciences-sector-plan; INQ000659799)
185 'WHO Member States conclude negotiations and make significant progress on draft pandemic agreement', World Health Organization, 16 April 2025 (https://www.who.int/news/item/16-04-2025-who-member-states-conclude-negotiations-and-make-significant-progress-on-draft-pandemic-agreement; INQ000587464); INQ000587665
186 *WHO Pandemic Agreement*, World Health Organization, 20 May 2025, pp15-16, 23-25, Articles 8, 13-14 (https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf; INQ000625631)
187 INQ000527714_0133 para 11.89d

to improving the UK's underlying domestic industrial resilience.[188] This includes public grants totalling £520 million and support packages for innovative life sciences manufacturing, with the aim of attracting private investment and strengthening supply chain resilience. There are aspirations for robotics, 3D printing, allowing advances in medical technology to be used more quickly, diversifying raw material supply chains and making supply chains more agile. However, *The UK's Modern Industrial Strategy* and the *Advanced Manufacturing Sector Plan* and *Life Sciences Sector Plan* do not address the specific needs of domestic healthcare equipment manufacturing in the event of a global pandemic.

4.88. Similarly, *The UK's Trade Strategy* acknowledges the importance of improving supply chain resilience and preparing for disruptions by building international partnerships. It also makes a commitment to establish a new Supply Chain Centre within the Department for Business and Trade to build resilience in areas critical to the UK's security and prosperity.[189] However, it does not directly address the risk to the UK from the concentration of healthcare equipment supply chains in China or the practical steps that will be taken to broaden the geographical range of the UK's healthcare equipment supply chains in advance of a future pandemic.

Diversification of supply and new trading partnerships

4.89. Prior to the outbreak of Covid-19, there was an expectation by the Department of Health and Social Care, Public Health England and Supply Chain Coordination Ltd that, in the event of a pandemic, there would be a properly functioning global market for key healthcare equipment such as PPE, which could be relied on by the UK government and devolved administrations.[190] According to Major General Phillip Prosser, Brigadier Commander of the 101 Logistic Brigade deployed to the PPE team within NHS England:

> "*I don't think we ever thought that a pandemic would … put a global demand signal on the global supply chain. I think we always thought that … the global supply chain would have the capacity to respond.*"[191]

4.90. Given the extent of global travel and trade, the planning by the Department of Health and Social Care, Public Health England and Supply Chain Coordination Ltd on the basis that global supply chains would not be disrupted by a pandemic was an error. A pandemic always had the potential to become global and the disruption

188 *The UK's Modern Industrial Strategy*, UK Government, June 2025 (https://webarchive.nationalarchives.gov.uk/ukgwa/20250623151801/https://www.gov.uk/government/publications/industrial-strategy; INQ000659798); *The UK's Modern Industrial Strategy: Advanced Manufacturing Sector Plan*, UK Government, June 2025 (https://assets.publishing.service.gov.uk/media/68920a3366bdd4490c61098f/industrial_strategy_advanced_manufacturing_sector_plan_accessible.pdf; INQ000659802); *The UK's Modern Industrial Strategy: Life Sciences Sector Plan*, UK Government, July 2025 (https://www.gov.uk/government/publications/life-sciences-sector-plan; INQ000659799)
189 *The UK's Trade Strategy*, UK Government, June 2025 (https://www.gov.uk/government/publications/uk-trade-strategy; INQ000659800)
190 INQ000528391_0004 para 11; INQ000492085_0029 para 9
191 Phillip Prosser 26 March 2025 166/3-8

of global supply chains and the bullwhip effect were the predictable consequences. There was, however, no strategy, guidance or planning for this eventuality.[192]

4.91. The reliance by the Department of Health and Social Care and Supply Chain Coordination Ltd on supply chains concentrated in a single region of the world compounded this error. It should have been recognised that, if a pandemic originated in such an important manufacturing region as China, this would have a major impact on the UK's supply of key healthcare equipment. The potential for disruption to these global supply chains would put the provision of PPE to front-line staff in the UK at risk and ought to have been factored into emergency planning for pandemic procurement.

4.92. Such planning may include a more robust PPE stockpile, so that procurement can be delayed until global supply chains have settled (see Chapter 1: The UK's readiness for emergency procurement and distribution). While this is part of the solution, it comes with added costs of management and storage – and is not sufficient on its own.[193] Another way to mitigate the bullwhip effect in the future would be to improve supply chain visibility. This could be achieved by parties in the supply chains gathering and sharing data on demand and forecasting, tracking and tracing goods and production capacity. This requires better technology.[194] This is examined in Chapter 7: Data, technology and the future of emergency procurement.

4.93. The concentration of supply chains originating in low-cost, mass-manufacturing countries such as China placed the UK's ability to respond effectively to the pandemic at the mercy of overseas manufacturers, foreign governments and a properly functioning international logistics system.[195] In a global health emergency, these cannot be guaranteed. For goods of critical importance (such as healthcare equipment in a pandemic), broadening the range of countries supplying the UK government and devolved administrations will mean they are better prepared in the future.[196]

4.94. In order to spread risk better, suppliers to the UK of healthcare equipment and the raw materials necessary for their domestic manufacture should be located across a range of countries and regions of the world. This will account for the unknowable geographic origin and spread of a future pandemic and the potential even for countries the UK considers are allies – in the grip of an emergency – to restrict supplies to the international market.[197] The concentration of supply chains, including for the sourcing of raw materials, and the risk this creates should be kept under regular review within pandemic preparedness plans to account for the prevailing global conditions.[198]

192 INQ000563395_0002 para 7
193 INQ000279940
194 INQ000474864_0022 para 90
195 INQ000474864_0053, 0056-0057 paras 220, 234
196 INQ000474864_0030, 0059 paras 120, 248
197 INQ000474864_0144 Author recommendation 25
198 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024, Recommendation 8 (https://covid19.public-inquiry.uk/documents/module-1-full-report)

A new plan for emergency international trade and domestic industrial resilience

4.95. As a pandemic is a potential threat to national security, the healthcare equipment needed to respond should be regarded by the UK government and devolved administrations as a strategic national asset and not subject entirely to the prevailing conditions of the market. The UK needs a comprehensive strategy that addresses emergency international trade and domestic industrial resilience together.

4.96. The UK government and devolved administrations should improve the long-term resilience of supply chains for key healthcare equipment in two ways:

- Firstly, the UK government should build partnerships with nations and trading blocs identified as strategic allies for the supply of key healthcare equipment during a future pandemic.
- Secondly, the UK government and devolved administrations should increase their own emergency domestic industrial resilience.

4.97. The Inquiry acknowledges the potential costs of building manufacturing resilience, and ultimately it is a matter of political choice. However, the supply of healthcare equipment is critical to being able to respond effectively to an emergency that threatens the life of the nation, and greater manufacturing resilience could have advantages for non-pandemic times.

4.98. The relative success of the Ventilator Challenge and rapid development of sophisticated Covid-19 testing technology demonstrate that the UK has the potential to provide global leadership in the design and manufacture of technical, cutting-edge healthcare equipment for general use as well as use in an emergency.[199] There is an opportunity for the UK government and devolved administrations to support their domestic manufacturing base by fostering an environment of innovation, research and development into the kinds of healthcare equipment needed for a future pandemic. As part of recent developments arising from the present industrial revolutions in technology and data, there is a prospect for the UK to build and transform manufacturing technologies and processes in support of pandemic preparedness.[200]

4.99. The Department of Health and Social Care's *Pandemic Preparedness Strategy* (March 2026) indicates that the UK government is building domestic industrial resilience, including through:

- a commitment by the Department of Health and Social Care to work with suppliers to incentivise the domestic manufacturing of PPE, generally and in a pandemic;

199 INQ000474864_0081 para 335
200 INQ000474864_0030, 0081-0082 paras 120, 337

- investment through the Life Sciences Innovative Manufacturing Fund to strengthen the UK's industrial capacity and capabilities; and
- closer collaboration between the UK Health Security Agency and industry to develop and manufacture testing equipment within the UK.[201]

These are positive steps.

4.100. Some countries with relatively high labour costs, such as Germany, have been able to build capacity for competitive domestic PPE manufacturing by adopting advanced manufacturing techniques that are fully or close to fully automated.[202] Similarly, the USA was a pioneer in the use of 3D printing to manufacture PPE during the pandemic, with the potential to transform PPE and healthcare equipment supply chains in the long term, making them less exposed to external shocks and more resilient.[203] If the UK government and devolved administrations provided the conditions and incentives for private investment in this kind of automated manufacturing technology, the UK could maintain a viable domestic manufacturing base for high-volume, low-cost critical equipment such as PPE.[204]

4.101. The experience of countries such as the USA and India during the pandemic demonstrates the potential of having a PPE manufacturing base that is able to scale up during an emergency.[205] This should form part of a broader strategy to ensure that, for the manufacture of healthcare equipment, the UK government and devolved administrations:

- provide industry with access to the necessary raw materials;
- enter into agreements with potential domestic manufacturers;
- incentivise private investment in automated manufacturing; and
- train a domestic labour force skilled in advanced manufacturing techniques.[206]

4.102. The new international trading and domestic industrial strategy should form a specific part of the UK-wide, whole-system civil emergency strategy recommended in the Inquiry's Module 1 Report (Recommendation 4). It should be kept up to date, be adaptable and keep pace with geopolitical developments.[207]

201 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, pp43-44 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)
202 INQ000474864_0025-0026 para 108
203 INQ000474864_0030 paras 121-122
204 INQ000474864_0137 para 609
205 INQ000474864_0082 para 340
206 INQ000474864_0082 para 338
207 Phillip Prosser 26 March 2025 162/17-164/11

Recommendation 7: Emergency international trade and domestic industry to form part of the whole-system civil emergency strategy

The UK-wide whole-system civil emergency strategy, which the Inquiry has recommended should be developed by the UK government and devolved administrations (see the Inquiry's Module 1 Report, Recommendation 4), should include specific objectives for international trade and domestic industry during a pandemic.

These must include:

- the establishment of trading alliances in advance of the next pandemic, to diversify overseas sources of raw materials and healthcare equipment;
- contractual arrangements with domestic and international suppliers of raw materials and healthcare equipment manufacturers which activate when a pandemic is declared;
- a robust plan to enable domestic manufacturers rapidly to retool and repurpose facilities for the production of healthcare equipment; and
- supporting investment for research and development into advanced manufacturing of healthcare equipment in the UK.

Chapter 5: Procurement and distribution expertise and experience

Introduction

5.1. The procurement and distribution of healthcare equipment involve astute commercial negotiation, the thorough assessment of options about what to buy, at what price and from whom, the calculated taking of commercial risk and organisation of a complex logistical operation. Procurement during the Covid-19 pandemic required all those skills and the ability to use them at times of extraordinary pressure.

5.2. This chapter examines the procurement and distribution expertise available to the UK government and devolved administrations, the dependence on the military during the pandemic and the use of external advisers and businesses. It analyses the evidence obtained in open hearings. Chapter 5A: Procurement and distribution expertise and experience contains the Inquiry's findings in relation to closed evidence regarding PPE Medpro Ltd and one of its two contracts to supply PPE. The closed evidence and Chapter 5A cannot currently be published, under the terms of a restriction order dated 24 January 2025, made pursuant to section 19 of the Inquiries Act 2005, in order to prevent a risk of prejudice to possible criminal proceedings.[1] That order only continues until the conclusion of any criminal proceedings (including prosecution, review and appeals) in relation to PPE Medpro Ltd or unless the order is varied or revoked pursuant to section 20 of the Inquiries Act 2005.

5.3. This chapter contains all the Inquiry's findings and recommendations about procurement and distribution skills, expertise and experience. The findings and recommendations set out below also draw on the evidence contained within Chapter 5A. When the restriction order is no longer in force, this chapter should be read together with Chapter 5A.

In-house procurement and distribution expertise

5.4. Central procurement bodies across the UK possess or have access to considerable expertise in general procurement and in the procurement of healthcare equipment. During the pandemic, officials applied their expertise, working at speed and under severe pressure. They were supported by teams of officials with experience in other areas from across government. While clearly doing the best they could under extreme circumstances, overall the teams of officials:

1 Inquiries Act 2005 (https://www.legislation.gov.uk/ukpga/2005/12/contents/enacted); 'Final Notice of Determination: Restriction Order Application in relation to the applications by the NCA dated 9 and 17 December 2024', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/final-notice-of-determination-issued-by-the-chair-of-the-uk-covid-19-inquiry-regarding-the-ncas-application-for-a-restriction-order-dated-24-01-2025); 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/restriction-order-issued-by-the-chair-of-the-uk-covid-19-inquiry-dated-24-01-2025)

- lacked the capacity and resources to respond effectively to the pandemic;[2]
- had an inconsistent understanding of key commercial principles;[3] and
- lacked specialist training and experience in emergency procurement, procurement of healthcare equipment and international coordination.[4]

Capacity and resources

5.5. Sir Gareth Rhys Williams, UK Government Chief Commercial Officer from March 2016 to July 2024, told the Inquiry that, while he considered that there was adequate procurement expertise within the Civil Service to respond to the Covid-19 pandemic, to maintain capacity officials were "*working day and night*".[5] Officials involved in the procurement of personal protective equipment (PPE) were sometimes handling more than 40 cases in parallel, each requiring dozens of telephone calls and emails.[6] Similar pressures were reported in the testing programme, with officials working long days.[7] As it was for many others working and living through the pandemic, the strain on procurement officials was extreme.

5.6. The limitations on in-house capacity and resources led to extensive reliance, especially by the UK government, on the skills, expertise and experience of the military, external advisers and businesses. It was only by harnessing these skills and ensuring that the public and private sectors worked together effectively that the UK was able to build its emergency procurement and distribution capabilities during the crisis.[8]

Understanding and applying key commercial principles and practices

5.7. One of the key features of pandemic procurement is the acute urgency with which the task of procurement – which in normal times could often take weeks or months to complete – has to be undertaken. Procurement officials were faced with adapting and applying their general procurement skills to the circumstances of the emergency. This meant that while operating under pressure they had to:

2 Albert Sanchez-Graells 4 March 2025 46/9-47/24; INQ000521972_0025 para 4.27
3 INQ000562340_0060-0061 paras 138-140
4 Christopher Young 25 March 2025 9/5-25; Andrew Slade 25 March 2025 68/10-25; INQ000540488_0012, 0019-0020 paras 3.27, 3.47b, 3.47i; Gareth Rhys Williams 4 March 2025 178/10-15; INQ000497031_0148 para 4.313.1
5 INQ000535017_0012 para 30
6 Chris Hall 6 March 2025 104/18-22, 105/10-20
7 INQ000562340_0074-0075 para 179
8 INQ000562340_0060-0061 paras 137e-138

- have a realistic understanding of negotiation in an emergency;
- effectively interpret and assess due diligence information (about the financial standing and credibility of a business);
- recognise and manage conflicts of interest; and
- incorporate key terms into written contracts.

Having a realistic understanding of negotiation in an emergency

5.8. Although some private suppliers donated PPE and other healthcare equipment to the UK government and devolved administrations during the pandemic, suppliers were generally businesses providing equipment for a profit.

5.9. James Bethell, Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021) told the Inquiry that if "*it hadn't had been for the profit motive … we wouldn't have had PPE*".[9] It was overwhelmingly private manufacturers, distributors and intermediaries, incentivised by profit, that supplied the UK and devolved administrations with large volumes of vital healthcare equipment at short notice. When global demand greatly exceeded supply at the start of the pandemic, it became a sellers' market and sellers could demand prepayment and other advantageous contractual terms.[10]

5.10. This was understood, and the aim of the Department of Health and Social Care was to be the "*'go to' customer for global suppliers of PPE*" and a "*brilliant buyer*", if necessary by taking on more risk and paying above market value for healthcare equipment.[11] Ministers such as Matt Hancock MP (Secretary of State for Health and Social Care from July 2018 to June 2021) and Rishi Sunak MP (Chancellor of the Exchequer from February 2020 to July 2022) agreed with this approach.[12]

5.11. The imperative remained to ensure value for money and avoid profiteering (ie a supplier making a large profit by taking advantage of the emergency).[13] Procurement officials in the PPE Cell (which was established by the Department of Health and Social Care in March 2020) were required to consider how profiteering could be limited. For example, officials had to record their reasons for certain procurement decisions in an internal form and had to address the question of how they intended to ensure that a supplier was not making large profits. In one instance in April 2020, the answer was as follows:

9 James Bethell 19 March 2025 26/15-18
10 INQ000474864_0019-0020 para 82; Jonathan Marron 5 March 2025 191/15-21, 192/4-11
11 INQ000088616_0006; INQ000088633_0004; Matt Hancock 19 March 2025 107/16-108/25, 110/15-111/5
12 INQ000088616_0006
13 INQ000513541

> "[T]*he critical shortage of PPE is the highest priority consideration, with financial considerations of lesser importance. To that end, no analysis has been conducted as to whether domestic firms are profiteering*."[14]

This was true, to some degree, for almost all offers of PPE made between February and May 2020 when the demand for PPE was at its height.[15] Prices for raw materials, manufacturing and transportation were volatile, particularly in the first half of 2020. The costs incurred by manufacturers and suppliers could fluctuate even during the time between an offer being made and the signing of a contract.[16]

5.12. Procurement officials were operating in a 'spot market' in which procurement was global, dominated by national governments with the largest budgets, and where orders were being negotiated between buyers and sellers at specific price points reflecting the market conditions at particular points in time.[17] It was incumbent on officials to negotiate the best terms they could in these obviously difficult circumstances but there was very little they could do to stop suppliers from taking advantage of market conditions by increasing their prices and profiteering.

5.13. As Sir Gareth Rhys Williams told the Inquiry, the UK government had not invested in its understanding of healthcare equipment supply chains and so had only "*limited information*" about where equipment was being manufactured, by whom and from what materials.[18] Suppliers with this kind of information could corner supplies of raw materials or buy up manufacturing time in factories, thus making large profits by capitalising on their market knowledge.[19]

5.14. As examined in Chapter 6: Transparency, governance and accountability, procurement officials in the Department of Health and Social Care did seek to determine whether potential contracts offered value for money. Procurement officials responsible for buying PPE generally accepted that they would have to pay prices far in excess of the pre-pandemic prices due to a shortage of supply and increased global demand. However, efforts were made to benchmark prices and to keep prices paid for PPE at no more than 25% above the average price paid at the time.[20]

5.15. In the procurement of testing equipment, for example, where global competition for equipment was especially fierce and the UK's plans to scale up capacity were ambitious, 10 Downing Street instructed officials rapidly to "*buy buy buy*" large quantities of lateral flow tests and to finalise deals within a day.[21] Procurement officials continued negotiations over a weekend and in the process secured

14 INQ000519157_0003-0004; see also INQ000519158_0004
15 INQ000528391_0005, 0136 paras 16, 498c; INQ000551593_0003
16 INQ000474864_0087-0090 paras 363-370
17 INQ000474864_0022 para 89
18 INQ000182611_0014-0015 para 5.9
19 INQ000182611_0014-0015 para 5.9
20 INQ000535017_0020-0021 para 52; INQ000497031_0009-0010, 0158, 0183 paras 1.26, 4.351, 4.451-4.454; INQ000528391_0132 para 490b
21 INQ000561757

"*hundreds of millions*" of pounds of savings for the taxpayer.[22] To engage in this kind of high-pressure commercial activity – and to be successful in securing supplies and obtaining value for money for the public – requires access to a cadre of officials with expertise in operating in volatile global markets. It is fortunate that on this occasion they were available.

5.16. A realistic understanding of some of the limits on negotiation in an emergency must be combined with a clear understanding of how the principles of public procurement should be applied in such a situation. Ministers and procurement officials have an obligation to ensure value for money for the taxpayer, no matter how inflated the price or how urgently the supplies are needed.[23] Stephen Barclay MP, Chief Secretary to the Treasury from February 2020 to September 2021, told the Inquiry that "*the principles can be consistently applied in terms of value for money as a Treasury test*", but in an emergency "*the application of that principle changes because what constitutes value for money is then different*".[24]

5.17. The UK government and devolved administrations were in competition with governments around the world. The price had to be considered alongside other competing factors, including the need for the equipment, its scarcity on the market, lead times and confidence in the supplier's ability to deliver.[25] It was not realistic to expect governments to prevent companies from profiting altogether; the pursuit of such a policy would have restricted the UK's ability to compete and procure PPE.

5.18. Potential methods of limiting the scope for suppliers to make large profits in a future pandemic include training procurement officials to negotiate contract terms, such as for suppliers to open their financial records or disclose their costs, or to set a maximum profit level – as happened with some suppliers in the Ventilator Challenge (see Chapter 2: Emergency procurement and distribution during the pandemic).[26] However, this may not always be acceptable to suppliers. The best defence against profiteering and exploitation in future would be to put in place systems and deploy technology that is able to provide information about the market, including price analysis and supply chain data (see Chapter 7: Data, technology and the future of emergency procurement).[27]

Effectively interpreting and assessing due diligence information

5.19. Due diligence checks are the process by which a buyer assesses a potential supplier's financial stability, operational capacity, compliance with legal and technical requirements and overall reliability in order to manage risk before entering into a contract. The precise interpretation and rigorous assessment of due diligence checks are critical to an effective emergency procurement system. Without proper

22 INQ000562340_0018-0019 para 26
23 *Managing Public Money*, HM Treasury, October 2007, p24, para 4.2.3 (INQ000092622)
24 Stephen Barclay 12 March 2025 107/25-108/4
25 INQ000528391_0136-0137 para 498d
26 INQ000497031_0086 para 4.89.5; INQ000539153_0160 paras 395-396
27 INQ000474864_0022 para 90

checks, there are increased risks of contracting with unscrupulous suppliers and wasting public money.[28]

5.20. In the initial weeks of operation, the team in the PPE Cell (which was responsible for undertaking the initial due diligence on UK companies) comprised only one or two people and had the capacity to complete only about 20 due diligence checks per day.[29] Procurement and due diligence expertise was brought into the PPE Cell from other departments, such as the Ministry of Defence and the Department for Education.[30] As "*accredited*" procurement officials joined the PPE Cell, the procurement response improved but there were still gaps.[31]

5.21. The PPE Cell did not have a mature system of due diligence checks in March 2020 and initially relied only on publicly accessible information about individuals and companies making offers.[32] Sir Gareth Rhys Williams told the Inquiry that to secure urgently needed healthcare equipment "*there was a greater than normal willingness to assume financial risk*".[33] There were gaps in the information available to procurement officials.[34] Most due diligence was conducted at the closing stage of an offer.[35]

5.22. The existence of gaps in information about suppliers will likely be the case in any emergency where information may be scarce but the need to procure equipment is urgent. In these circumstances, being able to decide on whether a risk should be taken with public money requires especially sound commercial judgement and experience of working in a crisis.

5.23. As Professor Albert Sanchez-Graells (expert witness on public procurement during emergencies) told the Inquiry, where judgement and discretion are key parts of a procurement system, officials require "*high levels of professionalisation and skill*".[36] In a future pandemic, it is essential that procurement teams have early access to a wide pool of commercial professionals, trained in the assessment of risk under pressure and in making sound but finely balanced decisions based on imperfect information.

Recognising and managing conflicts of interest

5.24. A key challenge for procurement systems is to address the potential for corruption and conflicts of interest.[37] The risk of a conflict of interest arises when a decision-

28 'Procurement Policy Note 01/21: Procurement in an emergency', Cabinet Office, February 2021, pp2-4, paras 8, 10 (https://assets.publishing.service.gov.uk/media/601ad2e5d3bf7f70b531ec1d/PPN-01_21-Procurement-in-an-Emergency.pdf; INQ000092624); INQ000539153_0075 para 252
29 INQ000497031_0180 para 4.34
30 Andy Wood 6 March 2025 170/22-171/9
31 Andy Wood 6 March 2025 170/16-171/23
32 Andy Wood 6 March 2025 170/22-171/9
33 INQ000497031_0181 para 4.441
34 INQ000501951_0007
35 INQ000497031_0180 para 4.34
36 INQ000539153_0016 para 38
37 INQ000539153_0019 para 48.2

maker has an 'interest' or a "*stake*" in the outcome of a decision.[38] Contracting authorities, such as the Department of Health and Social Care, are obliged to take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising from public procurement.[39]

5.25. Although conflicts of interest and pressure from referrers and suppliers were acute risks in the High Priority Lane (see Chapter 6: Transparency, governance and accountability), there was inadequate guidance and training by the Cabinet Office and Department of Health and Social Care for officials in identifying and mitigating conflicts of interest in the context of emergency procurement.[40] The Cabinet Office's guidance on managing conflicts of interest in 2019 summarised the requirements of The Public Contracts Regulations 2015 and directed officials to refer to their department's internal guidance.[41] These were sufficient for business-as-usual procurement where generally it was only the suppliers and officials in the contracting body who were involved. However, the guidance did not provide adequate practical assistance to officials in the highly pressured circumstances of the pandemic, where ministers, members of parliament and senior officials from other bodies may have also become involved in procurement, as was most acutely the case in the High Priority Lane.[42]

5.26. One important example of the business-as-usual approach not being suitable for the emergency procurement system established during the pandemic was the Department of Health and Social Care's conflict of interest declaration.[43] New suppliers were asked whether any of their employees directly involved in the proposed execution of the contract had any friends or relatives who were currently or in the last five years employed by or in post at the Department of Health and Social Care or its arm's length bodies and whether the organisation had any direct or indirect association with any employee or post at the Department of Health and Social Care or its arm's length bodies.[44] This drew the definition of conflict of interest too narrowly, excluding, for example, connections in other government departments whose officials had been seconded to the PPE Cell.[45] It increased the risk that conflicts of interest would not be detected at an early stage of the procurement process and would not be subject to adequate scrutiny.

38 The Public Contracts Regulations 2015, regulation 24 (https://www.legislation.gov.uk/uksi/2015/102/introduction/made)
39 The Public Contracts Regulations 2015, regulation 24 (https://www.legislation.gov.uk/uksi/2015/102/introduction/made)
40 Max Cairnduff 6 March 2025 59/8-60/19; Dawn Matthias 20 March 2025 19/17-23, 21/5-16
41 'Procurement Policy Note 01/19: Applying exclusions in public procurement, managing conflicts of interest and whistleblowing', Cabinet Office, 22 February 2019 (https://assets.publishing.service.gov.uk/media/5c6fc23940f0b647af8f35db/Procurement_Policy_Note_01_19_-_Applying_Exclusions_in_Public_Procurement__Managing_Conflicts_of_Interest_and_Whistleblowing.pdf; INQ000101269); *Applying Exclusions in Public Procurement, Managing Conflicts of Interest and Whistleblowing: A Guide for Commercial and Procurement Professionals,* Government Commercial Function, undated (https://assets.publishing.service.gov.uk/media/5c6fc258e5274a0ece3a9564/A_Guide_for_Commercial_and_Procurement_Professionals.pdf; INQ000549366)
42 *Boardman Report on Cabinet Office Communications Procurement*, Nigel Boardman, 8 December 2020, pp12-15 (https://assets.publishing.service.gov.uk/media/608a6e0ce90e076ab07a6d92/Boardman-Review-of-Cabinet-Office-COVID-19-Communications-Procurement-final-report.pdf; INQ000055888)
43 INQ000528391_0140 para 515
44 INQ000521666_0002
45 INQ000539153_0110 para 297.1

Case study: Ayanda Capital Ltd

Ayanda Capital Ltd was a company with which the Department of Health and Social Care entered into a contract to supply 50 million filtering facepiece respirator class 2 (FFP2) masks and 150 million fluid-resistant or 'IIR' masks for £252.5 million on 29 April 2020.[46]

One of the senior advisers to Ayanda Capital Ltd, Andrew Mills, was previously a member of the Board of Trade, a UK government advisory body overseen by the Secretary of State for the Department for International Trade.[47] During the procurement process, another official – Martin Kent, a Director within the Department for International Trade's COVID-19 Joint Action and Coordination Team – vouched for Mr Mills' credibility.[48]

The definition of a conflict of interest had been drawn narrowly, relating to connections with the Department of Health and Social Care family. Ayanda Capital Ltd therefore did not need to disclose Mr Mills' past connections with other parts of the UK government. Ayanda Capital Ltd was able to answer accurately a question about whether there were any conflicts of interest on the new supplier's form and declared no conflict.[49]

Darren Blackburn, Head of New Supplier Sourcing in the PPE Cell from April to July 2020, explained that the fact that Mr Mills had previously worked with the UK government gave him confidence that Mr Mills was trustworthy. Although it was not the only factor, in his view, appropriate weight had been given to the connections with the Department for International Trade.[50]

As one official was vouching for a company advised by an ex-official to be considered for a valuable PPE contract, there was at least the possibility or a perception of a conflict of interest. Ayanda Capital Ltd was awarded a contract but the conflict risk was not identified and mitigated in the emergency procurement process as it should have been.[51]

5.27. Better guidance about conflicts of interest was not available to procurement officials until the spring of 2021, by which time it was too late.[52] The High Priority Lane had

46 INQ000613602 row 18
47 INQ000527714_0164 paras 14.14-14.15; INQ000534943_0004-0009; INQ000534922; INQ000536359_0029 para 82
48 INQ000534943_0004-0009; INQ000536359_0027-0032 paras 77-92; Darren Blackburn 6 March 2025 75/4-77/17
49 INQ000521666_0002
50 Darren Blackburn 6 March 2025 76/21-23, 83/1-9
51 Darren Blackburn 6 March 2025 83/1-9; *R (Good Law Project Ltd & Anor) v The Secretary of State for Health and Social Care* [2022] EWHC 46 (TCC), p102, para 403 (https://www.bailii.org/ew/cases/EWHC/TCC/2022/46.html; INQ000534910)
52 'Procurement Policy Note 04/21: Applying exclusions in public procurement, managing conflicts of interest and whistleblowing', Cabinet Office, 20 May 2021, pp7-17 (https://assets.publishing.service.gov.uk/media/60a3bca7d3bf7f28907c2d99/PPN_04_21-_Applying_Exclusions_in_Public_Procurement__Managing_Conflicts_of_Interest_and_Whistleblowing.pdf; INQ000092628); Max Cairnduff 6 March 2025 60/16-19

been closed in May 2020 and by June 2020 the acute crisis in the emergency procurement of PPE had passed.[53]

5.28. As Professor Sanchez-Graells told the Inquiry, improving the effectiveness of emergency procurement in the future will require "*heightened conflict of interest controls*".[54] The particular risks of conflicts of interest in an emergency that arise, for example, from the establishment of a cross-departmental PPE Cell, a High Priority Lane and management of a large number of new suppliers within the procurement process – all under pressure – should inform training for procurement officials.[55]

Incorporating key terms into contracts

5.29. The primary factors relevant to the progress of an offer to supply healthcare equipment in an emergency should be its merits, such as the price, quality and speed of delivery. Those merits should be judged objectively by procurement officials; either an offer is 'good' on its own terms in that it makes a credible offer to supply the specified equipment on certain agreed terms, or it is not.

5.30. The Department of Health and Social Care had a standard set of contract terms and conditions for suppliers of healthcare equipment.[56] If procurement officials had additional expectations of a supplier and wished to incorporate more onerous or different terms, they should have ensured that they were agreed and incorporated into the contract with the supplier.

5.31. If, for example, they wished to agree advance payments to suppliers to secure an offer or to limit the level or distribution of a supplier's profits, they had access to professional lawyers to advise them and, provided it was appropriate, they could do so.[57] This is as important for emergency procurement as it is for procurement in normal times. One of the key differences in a pandemic is that purchasers, mandated by ministers, may be entitled to take greater risk with public money than in normal times to secure healthcare equipment quickly.[58]

5.32. Max Cairnduff, High Priority Lane and Donations Lead in the PPE Buy Cell (a sub-set of the PPE Cell) from April to May 2020, told the Inquiry that, as teams within the PPE Cell would carry out more thorough checks on suppliers, there was a "*low threshold*" initially to determine whether an offer to supply PPE was credible.[59] This increased the risk that irrelevant factors would be taken into account in the decision to progress offers to supply PPE.

53 INQ000497031_0057-0058 para 3.81; INQ000055888_0012-0015
54 INQ000539153_0158-0159 para 393
55 INQ000539153_0158-0159 para 393
56 INQ000528391_0133, 0148-0149 paras 490e, 543-547
57 INQ000528391_0133, 0148-0149 paras 490e, 543-547
58 INQ000088616_0006; Matt Hancock 19 March 2025 107/16-108/25, 110/15-111/5
59 INQ000536351_0017 para 7.2

5.33. In the High Priority Lane, suppliers were recommended by 'referrers', who were often high-profile individuals. As procurement officials often negotiated with or spoke to both referrers and suppliers about offers, the interpretation and assessment of due diligence about each of these parties were important. As examined in Chapter 6: Transparency, governance and accountability, procurement officials on occasion considered that factors such as the status of the referrer and the relationship between a referrer and the supplier were relevant to the awarding of a contract.

5.34. David Williams (Second Permanent Secretary to the Department of Health and Social Care from March 2020 to April 2021) told the Inquiry that his decisions to approve contracts were not affected by factors such as:

- the identity, status and position of the referrer, and the nature and extent of contact made by or on behalf of the referrer or supplier with officials or ministers;[60]
- the level and distribution of profits by a supplier;[61]
- any relationship between a referrer and a financial backer of the supplier;[62] or
- the referrer vouching for the supplier.[63]

5.35. However, Mr Williams was a very senior official and not as vulnerable to pressure as more junior officials. Contemporaneous emails show that High Priority Lane caseworkers were under considerable pressure to pay attention to and progress offers made by high-profile individuals.[64] Caseworkers needed more support and training to withstand the pressure on them.

5.36. The view of Professor Sanchez-Graells was that the negotiation of contracts in a future emergency could be improved through further training and professionalisation, including a "*serious investment*" in continuous professional development with a focus on commercial skills and contract negotiations.[65] The Inquiry agrees.

Expertise in healthcare equipment

5.37. Healthcare equipment has to meet stringent standards to be safe for use. During the pandemic, procurement teams had to navigate a complex web of rules and regulations (see Chapter 3: Regulation, inspection and enforcement). When those procurement teams expanded, they needed access to people with specialist expertise in healthcare equipment.

60 INQ000475015_0023 para 71
61 INQ000475015_0023 para 72
62 INQ000475015_0023 para 73
63 INQ000475015_0023 para 74
64 INQ000475069_0004-0005 paras 12-13; INQ000565319_0001; INQ000565309_0001; INQ000575149_0001; INQ000565246_0001; INQ000565172_0001; INQ000565162_0001; INQ000565284_0001; INQ000565432_0002; INQ000565322_0001
65 INQ000539153_0160 para 395

5.38. In England, expertise in PPE procurement was spread across NHS trusts and arm's length bodies, including NHS England and Supply Chain Coordination Ltd (the central procurement body for the NHS supply chain in England). As noted in Chapter 2: Emergency procurement and distribution during the pandemic, Supply Chain Coordination Ltd's team was small and generally sub-contracted its functions; its team could not be scaled up when the Covid-19 pandemic emerged. Procurement specialists from the Cabinet Office's Government Commercial Function and Complex Transactions Team, the Ministry of Defence and other UK government departments were deployed to assist the PPE Cell and, while they received training on healthcare equipment, this had to be done in the midst of the pandemic.[66] Andy Wood, Deputy Director, Commercial Specialist in the Cabinet Office and Lead for the PPE Buy Cell from March to July 2020, described having "*no expertise in PPE*".[67] While there was admirable dedication to the task, senior procurement officials, in charge of large sums of expenditure for critical healthcare equipment, were learning on the job.[68]

5.39. In Scotland, Gordon Beattie, Director of National Procurement at NHS National Services Scotland (known from 1 April 2026 as Public Services Delivery Scotland) from December 2019, said that most of his team had been in the NHS for 15 or 20 years.[69] Jeane Freeman MSP, Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021, said that NHS National Services Scotland was "*an established body of some standing*".[70] However, Paul Cackette, Director of the PPE Directorate in the Scottish Government from April to June 2020, explained to the Inquiry that the Scottish Government was "*unprepared in terms of the numbers and skillsets of the leaders and senior staff it needed. Too much was asked of too few.*"[71]

5.40. In Wales, the Commercial and Procurement Directorate sets procurement policy and works in conjunction with other Welsh Government directorates to advise on and help manage procurement exercises they are required to carry out, but it was not relied on to procure PPE during the pandemic.[72] The Welsh Government in fact relied on the experience in purchasing healthcare equipment of NHS Wales Shared Services Partnership's in-house procurement officials; they, in turn, made use of the technical skills and expertise of the Life Sciences Hub Wales to triage offers of supply and to provide technical expertise.[73]

5.41. In Northern Ireland, most healthcare-related procurement was carried out by the Business Services Organisation's Procurement and Logistics Service, which was the Centre of Procurement Expertise for the Department of Health (Northern Ireland).[74] Due to the reserved nature of international relations under the relevant

66 INQ000540488_0012 para 3.27
67 INQ000540488_0006 para 3.8
68 Andy Wood 6 March 2025 167/4-9
69 Gordon Beattie 24 March 2025 124/20-22
70 Jeane Freeman 24 March 2025 8/20-22
71 INQ000512904_0051 para 6.7; Gordon Beattie 24 March 2025 124/7-22
72 INQ000506956_0005-0006 paras 15-22
73 INQ000506956_0008 para 29; INQ000536425_0024 para 107; INQ000527715_0008-0013 paras 37-53
74 INQ000521964_0038 para 110

devolution settlement and the relatively small scale of business-as-usual healthcare equipment procurement in Northern Ireland, the Northern Ireland Executive had limited experience with or contacts in large-scale international procurement.[75] A large quantity of PPE was procured through a contact of an Executive Office official who had been posted to China in a previous role; however, this was "*borne more from circumstance/opportunity*" rather than any planned strategy on the part of the government of Northern Ireland.[76]

5.42. The devolved administrations were particularly limited by a lack of skills, expertise and experience in overseas healthcare equipment procurement. They had weaker purchasing power and a relative lack of in-country connections with the necessary expertise. This curbed their ability independently to acquire significant quantities of healthcare equipment from international sources.[77] The devolved administrations must be better prepared by improving their international healthcare equipment procurement expertise and by better sharing expertise and coordinating with the UK government, which, in comparison, has greater expertise and purchasing power.

Coordinating with expertise based overseas

5.43. It was not anticipated by the Department of Health and Social Care that the Foreign and Commonwealth Office or the Department for International Trade would have any significant role in procurement during a pandemic. Yet, at its peak, approximately 200 officials from the two departments were working in China alone on emergency procurement, with more officials in other locations around the world.[78] The Foreign and Commonwealth Office officials possessed valuable in-country expertise in languages and diplomacy, as well as connections with overseas officials, key manufacturers and distributors.[79] This enabled them to gather critical supplier and product information for the Department of Health and Social Care in the UK.[80]

5.44. The officials based overseas were not procurement specialists and did not have expertise in healthcare equipment. In addition, restrictions were placed on their movements. They were therefore heavily reliant on Department for International Trade officials and training that could be provided quickly and remotely by the Department of Health and Social Care.[81] In future, this training would be far more effective if the UK government ensured that those officials based overseas, especially in countries which have an important healthcare equipment manufacturing base or supply critical raw materials, have a basic knowledge and understanding of their potential role in procurement in an emergency and of procurement policies.[82]

75 Conor Murphy 26 March 2025 117/24-119/16
76 Tim Losty 19 March 2025 155/21-156/18
77 Conor Murphy 26 March 2025 117/24-119/16; INQ000320497_0005
78 Simon Manley 10 March 2025 82/10-18, 89/16-22
79 INQ000528393_0049 para 159
80 INQ000528393_0049 para 160
81 Simon Manley 10 March 2025 106/8-107/19
82 Simon Manley 10 March 2025 108/11-21

Dependence on the military

5.45. In emails in March 2020 between NHS England and the Ministry of Defence, described as "*the first report from the battlefield*", the lack of skills, experience and expertise in emergency procurement and distribution available to NHS England and Supply Chain Coordination Ltd was laid bare:

> "*The NHS supply chain for PPE is falling apart. They urgently need assistance. This is a large scale request, enduring for a number of weeks, to PLAN and EXECUTE elements of the NHS supply chain for PPE … There is no commercial capability in this time frame.*"[83]

5.46. As Major General Phillip Prosser (Brigadier Commander of the 101 Logistic Brigade deployed to the PPE team within NHS England) told the Inquiry, NHS England "*did not have the national planning experience or capability*" and Supply Chain Coordination Ltd "*lacked confidence*" in its ability to deliver PPE to the health and social care sectors.[84] Mr Wood told the Inquiry that, when the PPE Cell was established by the Department of Health and Social Care, he did not remember:

> "*having access to anyone that was used to these emergency situations, apart from the military logistics team*".[85]

5.47. The Army is uniquely experienced in responding to severe emergencies, and the 101 Logistic Brigade – an Army division which provides logistical support in battlefield conditions – was exceptionally well placed to assist with organising the logistics and distribution of PPE to the health and social care sectors.[86] During the pandemic, the Army was instrumental in logistics and distribution planning, scaling up distribution capacity and providing advice and feedback on how officials could improve the system.[87] It brought to the emergency procurement and distribution operation discipline, tempo and resilience, and instilled a "*wartime mindset*", faster decision-making and a pace of work not previously present in NHS England or the PPE Cell.[88]

5.48. These may be features of military experience and skill, but governments across the UK can learn critical lessons from the Army's involvement in the pandemic. If the UK and devolved administrations are to be better prepared for emergency procurement and distribution in a future pandemic, officials should be trained to operate, like the Army, as "*high-performance teams*", with similar abilities in planning under pressure, pace and purpose.[89]

83 INQ000534264_0002
84 INQ000560895_0005, 0011-0012 paras 16, 31-33
85 INQ000540488_0020 para 3.47i
86 INQ000560895_0002 para 5; Phillip Prosser 26 March 2025 132/19-133/14
87 INQ000572261_0014, 0032 paras 62, 143
88 INQ000560895_0014-0015 para 41; Phillip Prosser 26 March 2025 151/5-11
89 Phillip Prosser 26 March 2025 153/16-25

5.49. In Wales, the Army carried out assessments of distribution arrangements on two occasions and provided detailed advice and logistics and inventory management training to officials.[90] In Scotland, while the Scottish Government considered requesting deployment of the Army for delivering PPE, ultimately it was not considered necessary.[91] The Army did work with NHS National Services Scotland to offer system improvements to their logistics operations, although this was not without teething problems. Mr Cackette told the Inquiry that, while he welcomed the Army's offer of assistance, it needed to be better coordinated with officials in order to be less disruptive and more effective.[92] In Northern Ireland, although military assistance was requested to redistribute healthcare equipment between hospitals, the Business Services Organisation's Procurement and Logistics Service was able to increase its distribution operation sufficiently by procuring distribution and logistics services from the private sector.[93] The smaller scale of the country was an advantage.

Risks of overreliance on the military

5.50. The Army's principal role is the defence of the realm, providing an effective deterrence with a credible warfighting force. As Major General Prosser put it:

> "[I]*f that warfighting force is fixed delivering a peacetime or a homeland contingency task, then you're going to undermine that credibility of that deterrence*."[94]

While the deployment of the Army to organise the distribution of PPE during the Covid-19 pandemic was vital and understandable, it came with risks to the security of the UK. The Army's deployment in domestic emergencies such as a pandemic must remain a last resort.[95]

5.51. The Army's involvement with logistics and distribution was a significant undertaking. Had the Army become responsible for the distribution operation on its own, as was initially envisaged in March 2020 by Jin Sahota (Chief Executive Officer of Supply Chain Coordination Ltd from July 2017 to December 2020), it could have taken up to "*5,000 to 8,000 soldiers*" and "*18 months to two years*" for the Army to extract itself from the operation.[96] There was a real risk of mission creep if the Army's role and responsibilities had been expanded to meet the scale of the task. This would have distracted the Army from its primary role.[97] As clear boundaries were placed on the Army's involvement and Clipper Logistics plc was engaged to assist in the

90 INQ000506956_0075 paras 326-327; INQ000299126; INQ000527571_0044 para 167
91 INQ000512904_0013-0015 para 2.34
92 INQ000512904_0034 para 3.110
93 INQ000538646_0038 para 131; INQ000514103_0064-0066 paras 200-206
94 Phillip Prosser 26 March 2025 146/5-8
95 Phillip Prosser 26 March 2025 134/6-9
96 Phillip Prosser 26 March 2025 143/23-144/6
97 Phillip Prosser 26 March 2025 143/18-146/8

distribution operation, that risk did not materialise, but, without adequate planning, it could in the event of a future pandemic.

Improving in-house skills and expertise in emergency procurement and distribution

5.52. The UK government and devolved administrations need an in-house workforce capable of being deployed in a pandemic, with the skills, expertise and experience to procure and distribute healthcare equipment in an emergency. This workforce needs to be able to work in crisis response and be capable of assessing risk and making carefully balanced procurement decisions on the basis of limited information and under pressure. For emergency procurement, officials need not only expertise but also commercial acumen and the ability to manage potential suppliers robustly.

5.53. The PPE Cell used all the commercial skills and experience it could muster but the truth was that it had "*no experience of managing in such a crisis*".[98] The pace of events was "*breathtaking*" and even highly experienced procurement officials described the situation as unprecedented.[99] The exercise of commercial judgement under the high pressure of procurement in a pandemic is difficult without a specific background in emergency procurement, adequate training and guidance or experience. Such training and guidance should be sufficiently flexible to respond to the novel aspects of each crisis and not so dense or complex that they are unusable in an emergency. While, as examined in Chapter 3: Regulation, inspection and enforcement, there is a case for a simplified buyer's guide, this should be underpinned by a rigorous programme of training to build the underlying procurement and distribution workforce capacity of the UK and devolved administrations.

5.54. To avoid reliance on the Army, officials should also be trained in sufficient numbers to be able effectively to organise and establish a complex distribution operation, although, as examined below, one which may also require external support. This emergency procurement expertise should be retained within the central healthcare equipment procurement bodies across the UK: Supply Chain Coordination Ltd for the NHS supply chain in England, Public Services Delivery Scotland (established in April 2026 as the successor to NHS National Services Scotland), NHS Wales Shared Services Partnership and the Business Services Organisation's Procurement and Logistics Service in Northern Ireland.

5.55. Officials who are likely to be engaged in healthcare procurement during any future pandemic should undergo a programme of training to foster a consistent and objective understanding of the core principles of emergency procurement and their practical application in volatile markets. The training should include how to work

98 INQ000540488_0061 para 12.3
99 INQ000540488_0061-0062 para 12.4; INQ000562340_0074-0075 para 179

effectively with the emergency regulations and buyer's guide recommended in Chapter 3: Regulation, inspection and enforcement. This programme of training should be established for all current procurement officials and a wider pool of officials who will form part of a reserve specialist emergency procurement and distribution cadre.

Recommendation 8: A programme of training in emergency procurement and distribution of healthcare equipment

The UK government and devolved administrations should each establish a pool of officials who are trained in the emergency procurement and distribution of healthcare equipment.

Completion of the training should be mandatory for at least 20% of the workforce of each nation's central healthcare equipment procurement bodies and kept up to date through annual refresher courses.

Skills, expertise and experience of external advisers

5.56. There were key skills, expertise and experience which either did not exist within the UK government and devolved administrations at all or were not available in sufficient numbers to respond effectively to the procurement and distribution demands of the pandemic. In addition to a supplementary workforce, the UK government, in particular, required external expertise in several areas, including:

- project management;
- supply chain resilience;
- due diligence;
- modelling and data analysis; and
- logistics and distribution.[100]

5.57. In each case, external advisers made important contributions to the pandemic response. It is not practical or cost-effective for the UK government and devolved administrations to retain in house every kind of expertise in emergency procurement and distribution in sufficient numbers for a future pandemic. In advance of an emergency, the UK government and devolved administrations need to know which external advisers will be best able to work with and support ministers and officials in their response to a crisis.

100 INQ000539152_0005-0006 para 11; INQ000533610_0003-0004, 0013-0014 paras 15-17, 65-68; INQ000497031_0126-0127, 0148-0149, 0180 paras 4.232, 4.313.2, 4.436

Agreed ways of working with external advisers

5.58. While external advisers filled gaps in the skills and capacity of the Civil Service, the way they worked with officials during the pandemic was developed during the crisis, with the pressure and increased workloads that involved. Between officials and external advisers, there was:

- a poor understanding of their differences in working cultures and practices;[101]
- a lack of clarity about where authority lay;[102] and
- a difference in approach to supervision.[103]

5.59. The under-representation of experienced officials to supervise external advisers and a lack of time to train and properly induct them meant that they had a poor understanding of some of the practices and procedures of the Civil Service. This was worsened by a high turnover of external advisers during the pandemic, rendering it more difficult to build institutional knowledge and shared working practices.[104]

5.60. The leadership and direction of the work of external advisers should always come from ministers and officials, as only they are accountable for the actions of the government. In preparation for a future emergency, officials should be trained in how to collaborate with and manage external advisers better. This should include:

- clarifying lines of accountability;
- ensuring that there is appropriate oversight; and
- inducting and managing external advisers in the culture and practices of the Civil Service.

5.61. In September 2022, *The Consultancy Playbook* was published.[105] While addressing some of the issues set out above, it does not provide a blueprint for the use of external advisers in an emergency or specifically in a pandemic where, due to the pressures and workload, there are likely to be particular risks to the integrity of decision-making in government.[106] It should be updated to address better ways of working with external advisers specifically in emergencies, including:

101 INQ000562340_0059-0061, 0068-0070 paras 137b-137d, 138-140, 166b-166c
102 INQ000562340_0059-0061, 0068-0070 paras 137b-137d, 138-140, 166b-166c
103 INQ000535017_0013 para 32; INQ000562340_0060-0061 paras 138-140
104 INQ000562340_0060-0061 para 138; INQ000587258_0002 para 5
105 *The Consultancy Playbook: Government guidance on how to commission and engage with consultants more effectively, achieving better outcomes, better value for money and supporting Civil Service capability through the creation of knowledge and skills*, HM Government, September 2022 (https://assets.publishing.service.gov.uk/media/631f2237e90e077db807dd00/The_Consultancy_Playbook_Version_1.1_September_2022.pdf)
106 INQ000535017_0033-0034 para 93; INQ000562340_0076 para 183

- advice on how to select and procure external advisers for an emergency;
- an outline of the minimum levels of governance and oversight that must be applied; and
- guidance on how to define work and lines of accountability and how to ensure integrity in decision-making.

Building effective partnerships with external advisers

5.62. By better recognising the existing expertise within the Civil Service, instituting a programme of training and combining this with the skills, expertise and experience of external businesses, the UK and devolved administrations will be better prepared to ensure that critical healthcare equipment is procured and delivered to the health and social care workforce. As Major General Prosser told the Inquiry, 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.*"[107]

5.63. According to Paul Deighton, Lord Deighton, who led the UK government's procurement of PPE from April 2020, one of the areas in which external advisers excelled was where they had significant experience of what he called "*delivery*" or getting things done.[108] They could also relieve procurement officials who were exhausted by responding to the crisis or bring a new focus to solving what appeared to be intractable problems.[109] The public and private sectors possessed different skills and the key was to get them to work together effectively.[110] As Lord Deighton told the Inquiry, what was essential was:

> "*an ability to integrate … the private sector capacity to drive, innovate and deliver, with the public sector's understanding of how you get things done in government*".[111]

5.64. Getting the balance right between well-trained in-house expertise and high-quality external advisers able to work effectively with officials requires planning. The UK government and devolved administrations should first identify the existing emergency procurement and distribution skills within the Civil Service.[112] The UK government and devolved administrations then need to know which external advisers they are likely to need and will be the most effective at supporting the emergency procurement and distribution response. Some progress will be achieved

107 INQ000560895_0026 para 82
108 Paul Deighton 18 March 2025 63/17-20
109 Paul Deighton 18 March 2025 66/10-16
110 Paul Deighton 18 March 2025 65/2-4
111 Paul Deighton 18 March 2025 64/23-65/4
112 INQ000572261_0049 para 205

through amending existing guidance and developing training about how officials should work with external advisers in emergencies. However, better planning also requires the UK government and devolved administrations to identify those external advisers with demonstrable competence in areas which support the emergency procurement and distribution of healthcare equipment.[113] This should be done before a future pandemic.

5.65. The early identification of such external advisers will be of greatest assistance in decreasing the risk of having to rely on the Ministry of Defence and the Army to support crisis organisation, logistics and distribution. As it is not realistic for the UK government and devolved administrations to have on standby the large workforce or infrastructure required for pandemic distribution operations across the UK, it is critical that the advisers identified include those who are able to organise and establish at speed operations similar to the complex operation that the Army oversaw at the start of the pandemic. This will allow the Army to focus on its key task.

5.66. While the principal role of those external advisers who are identified will be to assist the government in its response, one of the benefits of their being pre-approved specifically for their expertise in emergency response is that they could also be called upon to provide advice and assistance to the government on the feasibility of its preparedness and planning for procurement and distribution in a pandemic. For example, a business with expertise in logistics and distribution could be called upon to advise on the workability of plans, or a supply chain company could advise on developments in the resilience of global supply chains. This would have the added benefit of the government and the external advisers learning how to work together in advance of a future pandemic and would build preparedness for future collaboration into the system.

An emergency procurement and distribution framework

5.67. It was only by combining the skills, expertise and experience in the public and private sectors during the pandemic that the procurement and distribution of healthcare equipment could be undertaken. The UK government and devolved administrations cannot train officials in all of the necessary skills and expertise for the emergency procurement and distribution of healthcare equipment and supplies. Nor can governments expect to have in house and ready all the necessary infrastructure and tools required to respond to a procurement and distribution emergency.

5.68. In advance of a future pandemic, the UK government and devolved administrations should establish a commercial framework agreement specifically for external advisers on the emergency procurement and distribution of healthcare equipment. The external advisers should be able to demonstrate as a minimum:

113 INQ000587258_0002-0003 para 7ii; INQ000562339_0024-0025 para 6.6

- an up-to-date knowledge of emergency procurement of healthcare equipment in a pandemic;
- expertise in their specialism and its application to the emergency procurement of healthcare equipment;
- an understanding of the culture and practices of the Civil Service; and
- value for money.

This will ensure that the UK government and devolved administrations will have identified in advance of a pandemic those with the best capabilities and capacity to assist in the response.

Recommendation 9: A commercial framework agreement for the emergency procurement and distribution of healthcare equipment

The UK government and devolved administrations should collaborate to establish a UK-wide commercial framework agreement of pre-approved external specialists in the emergency procurement and distribution of healthcare equipment.

The framework should be refreshed every three years.

Chapter 5A: Procurement and distribution expertise and experience

5A.1 Chapter 5A: Procurement and distribution expertise and experience contains the Inquiry's findings in relation to closed evidence regarding PPE Medpro Ltd and one of its two contracts to supply PPE. The closed evidence and Chapter 5A cannot currently be published, under the terms of a restriction order dated 24 January 2025, made pursuant to section 19 of the Inquiries Act 2005 in order to prevent a risk of prejudice to possible criminal proceedings.[1] That order only continues until the conclusion of any criminal proceedings (including prosecution, review and appeals) in relation to PPE Medpro Ltd or unless the order is varied or revoked pursuant to section 20 of the Inquiries Act 2005.

1 Inquiries Act 2005 (https://www.legislation.gov.uk/ukpga/2005/12/contents/enacted); 'Final Notice of Determination: Restriction Order Application in relation to the applications by the NCA dated 9 and 17 December 2024', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/final-notice-of-determination-issued-by-the-chair-of-the-uk-covid-19-inquiry-regarding-the-ncas-application-for-a-restriction-order-dated-24-01-2025/); 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/restriction-order-issued-by-the-chair-of-the-uk-covid-19-inquiry-dated-24-01-2025)

Chapter 6: Transparency, governance and accountability

Introduction

6.1. In response to the Covid-19 pandemic, the UK government and devolved administrations spent very large sums of money over a short time period to purchase healthcare equipment. The aim was to protect the public and especially health and social care workers from the spread of the virus.

6.2. The greatest expenditure of public money on healthcare equipment was by the UK government. Between March and June 2020, the Department of Health and Social Care purchased 20.8 billion items of personal protective equipment (PPE) through contracts worth approximately £8.6 billion, and Supply Chain Coordination Ltd (the central procurement body for the NHS supply chain in England) procured 17.4 billion PPE items through contracts worth approximately £5.2 billion.[1] The Department of Health and Social Care classified 3.86 billion items of PPE that had been supplied as not fit for onward distribution and identified that £2.6 billion of public money was "*at risk*".[2]

6.3. The public's trust in government procurement in part depended on it ensuring that adequate supplies of PPE, ventilators and testing equipment reached those who needed them. However, it also depended upon those responsible for procurement being open about how money was being spent. Public confidence demands that there is adequate scrutiny and control over expenditure. The public is entitled to know that public money is being spent properly and that there is value for money (buying goods at the lowest price in the circumstances). Where there is a lack of transparency, or doubt, trust will diminish.

6.4. This chapter examines the measures taken to ensure that the procurement of vital, life-saving healthcare equipment, in particular PPE, was not only pursued quickly but was balanced with the need for transparency, governance (including value for money) and accountability.

Transparency

6.5. In public procurement, transparency means being open about how governments operate – ensuring that their actions, decisions and processes are clearly recorded, accessible and understandable to the public. This includes broadly publicising contract opportunities and publishing as much information about contracts awarded using public money as quickly as possible.[3] As Daniel Bruce (Chief Executive of Transparency International) told the Inquiry, transparency "*leads to better procurement outcomes*"; more transparency ensures that government is able to make better decisions about the spending of taxpayer money.[4]

1 INQ000528391_0005-0006, 0192 paras 17, 729
2 INQ000528391_0007, 0231 paras 21, 869
3 INQ000539153_0015-0016 paras 35-37
4 Daniel Bruce 4 March 2025 124/1-23; Gareth Rhys Williams 5 March 2025 182/3-10

6.6. The publication of contract details may reveal patterns of unduly advantageous contract terms and bias or, on the contrary, the existence of a level playing field. Greater and earlier transparency with the public about procurement decisions in the pandemic would have helped reduce potentially unfounded criticism and suspicion of ministers and officials. Where there was a lack of transparency as to how contracts were awarded, the vacuum of information was filled with suspicion, accusations of cronyism (the award of contracts to friends or associates without due regard to an offer's merits) and concerns about corruption.[5] A failure to be transparent erodes public trust.[6]

6.7. In particular, external scrutiny, including by the public, increases the likelihood that governments obtain value for money, reveals any unfairness in the terms and award of contracts, and increases competition, as other suppliers are informed of the contracts offered, which can result in lower prices and better value for money.

Publication of contract information

6.8. The rules in England, Scotland, Wales and Northern Ireland required the publication of contract award notices (which set out key information, including the date of the contract award, the supplier and the value of the contract) within 30 days.[7]

6.9. There are generally minimum timescales of between 40 and 65 days in which public bodies may conduct an open, competitive procurement process to provide potential suppliers with an opportunity to bid for the award of contracts.[8] Direct awards may be made where it is not possible to comply with the usual timescales for competitive procurement, but only if certain conditions are met, including in an "*extreme emergency*".[9] The direct award of contracts does not require an open competition or compliance with certain rules.[10]

6.10. In March 2020, the Cabinet Office issued Procurement Policy Note 01/20 for England and Wales, which confirmed that, notwithstanding the increased pressure of the pandemic, proper records should be kept and that, when making a direct award, a contract award notice should still be published within 30 days of awarding a contract.[11]

6.11. Despite the widespread use of direct awards during the pandemic to speed up procurement, the transparency obligations of the UK government and devolved administrations remained broadly the same in the pandemic as they were in

5 INQ000527634_0079 para 212; INQ000497031_0013, 0043-0044 paras 1.35, 3.28
6 Gareth Rhys Williams 4 March 2025 172/14-21
7 The Public Contracts Regulations 2015, regulations 50, 112 (https://www.legislation.gov.uk/uksi/2015/102/content); The Public Contracts (Scotland) Regulations 2015, regulation 51 (https://www.legislation.gov.uk/ssi/2015/446/contents/made)
8 INQ000539153_0026-0028, 0046-0048 paras 72-78, 139-146
9 INQ000539153_0052 para 163
10 The Public Contracts Regulations 2015, regulation 32 (https://www.legislation.gov.uk/uksi/2015/102/content); The Public Contracts (Scotland) Regulations 2015, regulation 33 (https://www.legislation.gov.uk/ssi/2015/446/contents/made)
11 INQ000497031_0048-0049 paras 3.41-3.42; INQ000048822_0003

normal times.[12] The same or similar principles applied across the UK (subject to some differences examined below), so that the four nations of the UK had similar publication duties.[13]

6.12. While there was no evidence of a deliberate policy of deprioritising the publication of adequate information about the contracts for PPE, the UK government and devolved administrations all failed in their duty to publish notices within the applicable timeframes.[14] By way of illustration:

- In England, the Department of Health and Social Care failed to publish contract award notices for 504 of 535 PPE direct award contracts (94%) awarded on or before 7 October 2020 within the 30-day deadline.[15]
- In Scotland, NHS National Services Scotland failed to publish contract award notices for 59 of 74 PPE direct award contracts (80%) within the 30-day deadline.[16]
- In Wales, NHS Wales Shared Services Partnership failed to publish contract award notices for a number of its 35 PPE direct award contracts within the 30-day deadline.[17] Audit Wales identified that, of 16 contracts subjected to a dip sample, 9 contract award notices were published outside the statutory deadline, and 4 contracts had information relating to an intermediary as opposed to the actual contracting party published because the contracting party was located in a country to which the rules did not apply. This lack of transparency is of particular concern given that only 35 contracts were awarded in total.[18]
- In Northern Ireland, the Business Services Organisation's Procurement and Logistics Service failed to publish contract award notices for 7 of its 48 PPE direct award contracts (14.6%) within the 30-day deadline.[19]

6.13. There were similar delays by the Cabinet Office in the publication of contract information for both the Ventilator Challenge (a programme established to ramp

12 Albert Sanchez-Graells 4 March 2025 31/3-10, 32/10-17

13 INQ000539153_0063 para 201; *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers,* Northern Ireland Audit Office, 1 March 2022, p48, para 4.19 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882); INQ000514103_0027-0028 para 63

14 Gareth Rhys Williams 4 March 2025 181/20-24; INQ000521969_0066-0067 para 278; INQ000528102_0023 para 82; *Procuring and Supplying PPE for the COVID-19 Pandemic*, Audit Wales, April 2021, p45, paras 2.29-2.31 (https://www.audit.wales/sites/default/files/publications/PPE%20-English_0.pdf; INQ000214235); INQ000527634_0142 para 344

15 INQ000528391_0159 paras 590-591

16 *Covid-19: Personal Protective Equipment*, Audit Scotland, June 2021, p18, para 39 (https://audit.scot/uploads/docs/report/2021/briefing_210617_ppe.pdf; INQ000108737)

17 INQ000575089_0013 para 49; INQ000536425_0058 para 227

18 *Procuring and Supplying PPE for the COVID-19 Pandemic*, Audit Wales, April 2021, pp4, 45, paras 4, 2.29 (https://www.audit.wales/sites/default/files/publications/PPE%20-English_0.pdf; INQ000214235)

19 *The COVID-19 Pandemic: Supply and Procurement of Personal Protective Equipment to Local Healthcare Providers,* Northern Ireland Audit Office, 1 March 2022, p48, paras 4.18-4.19 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2022-03/niao-report-the-covid-19-pandemic-supply-and-procurement-of-ppe-to-local-healthcare-providers_web_final.pdf; INQ000348882); INQ000514103_0027-0028 para 63

up the domestic manufacture of ventilators, examined in Chapter 4: Global supply chains and domestic industrial resilience) and by NHS Test and Trace for testing equipment.[20]

6.14. The Inquiry was told that, due to the increased workload and intense pressure of the pandemic, ministers and procurement officials in the UK government and devolved administrations prioritised the emergency procurement and distribution of healthcare equipment as quickly as possible over transparency.[21] As Matt Hancock MP (Secretary of State for Health and Social Care from July 2018 to June 2021) stated, the approach was to "*deal with any legal headaches later … the primary goal above all else was to save lives*".[22]

6.15. On a small but still concerning number of occasions, freedom of information requests and even threats of litigation from transparency campaigners and special interest groups were required before contract information was published or the scale of the problem with transparency during the pandemic was publicly acknowledged.[23]

6.16. Delays in publishing contract information may have been understandable in the early days of the crisis but became less so as the pandemic developed. Protection of the public in a pandemic must always take priority, but openness about major spending decisions should not be deprioritised. It may undermine public confidence in the pandemic response, in public procurement and in government more generally.

Allocation of resources to publishing information

6.17. Publication of contract information was an onerous and time and resource-intensive administrative task. Information for publication was often compiled by officials manually searching and sifting large quantities of data from multiple sources and systems.[24]

6.18. During the Covid-19 pandemic, this problem was made more acute as procurement was conducted by large numbers of officials, spread across different departments and teams, often using different and outdated IT systems and relying on emails and shared mailboxes to transfer and examine large quantities of procurement data.[25] There were concerns in the Cabinet Office, for example, that incorrect information in contract award notices could result in public criticism and litigation. Government departments were therefore required to verify information manually prior to the

20 INQ000527634_0065-0067 paras 171-175; INQ000497031_0044 para 3.29; INQ000497031_0013 para 1.35; INQ000521972_0035 para 4.66; INQ000562340_0062 para 144
21 INQ000514103_0027-0028 para 63; Andrew Slade 25 March 2025 59/6-9; INQ000536425_0057 para 227; INQ000514103_0027-0028 para 63; INQ000521969_0051 para 201; INQ000528102_0023 para 82; INQ000528391_0159-160 paras 588-592
22 INQ000536350_0010-0011, 0048 paras 48, 221
23 INQ000527634_0048-0052 paras 116-128; INQ000527634_0066-0067 paras 170-175; INQ000527634_0092 para 240; INQ000534975_0003 para 2; INQ000540760_0012-0013 paras 28-33
24 INQ000540760_0013 para 32; INQ000521969_0051 para 201; INQ000521969_0066-0067 para 278; INQ000514103_0027-0028 para 63; INQ000521972_0035 para 4.66; INQ000562340_0062 para 144
25 INQ000528391_0160 para 594

publication of contract award notices.[26] Although understandable, this inevitably led to further delays.

6.19. The key bodies responsible for healthcare equipment procurement across the UK cited insufficient time and resources and also inadequate software during the pandemic as the key reasons for late publication.[27] The preparation of contract award notices by the Department of Health and Social Care and the Cabinet Office was generally "*a complex, labour-intensive and time-consuming process*".[28] In his May 2021 report, Sir Nigel Boardman (who was appointed by the UK government to conduct a review of pandemic procurement) noted that there were "*systems and data weaknesses*" and "*a lot of manual uploading*", which led to delays.[29] The system for gathering, analysing and publishing contractual data was slow, cumbersome and archaic.

6.20. Given the speed and scale of procurement and the volume of material generated, the teams were ill equipped – while focusing on procurement and distribution – to keep pace with the manual collection, checking and publication of data in the form of contract award notices. As examined in Chapter 7: Data, technology and the future of emergency procurement, this problem may be solved with improved information systems.

Gaps in transparency obligations

6.21. There were differences in the transparency obligations between the UK government and devolved administrations, and between England, Wales and Northern Ireland on the one hand and Scotland on the other.

6.22. The UK government was required to publish contract award notices, irrespective of where in the world the supplier was based.[30] By contrast, the rules placed no obligation on the devolved administrations to publish contract award notices where the counterparty was based outside the European Union (EU) or in a state not party to the World Trade Organization Agreement on Government Procurement.[31] This meant that there was no publication requirement for the devolved administrations if the counterparty was based in China – one of the foremost countries in which manufacturers and distributors of PPE were based (see Chapter 4: Global supply chains and domestic industrial resilience).[32]

26 INQ000497031_0044 para 3.30
27 INQ000514103_0027-0028 para 63
28 INQ000528391_0160 para 594
29 *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021, p21 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876)
30 INQ000659755_0003 para 10
31 INQ000659756_0005 paras 17-18
32 Jonathan Irvine 25 March 2025 141/1-18; INQ000659756_0005 para 18

6.23. As an example of how this difference in rules had an effect, information published for the highest-value contract for PPE by NHS Wales Shared Services Partnership did not name the actual supplier, which was based in China, but only a company based in Wales. The Welsh company had merely acted as a broker for the deal.[33] NHS Wales Shared Services Partnership considered that there was not any requirement to publish the name of the actual supplier in China. As a result, NHS Wales Shared Services Partnership risked creating the impression that a large amount of taxpayer money had been spent within Wales, to the benefit of a Welsh business, when this was not the reality of the arrangement.[34]

6.24. In Scotland, there were subtle but important differences in transparency obligations compared with England, Wales and Northern Ireland. Contract values are crucial to showing the public a realistic picture of how public funds are spent. However, until December 2024 and the signing of an international treaty by the UK government, it was not deemed necessary by the Scottish Government to publish them.[35]

6.25. As the Procurement Act 2023 (see below) does not extend to Scotland, there continues to be a different approach in Scotland compared with England, Wales and Northern Ireland. Scottish procurement regulations continue to be in line with EU law, creating further divergence from England, Wales and Northern Ireland.[36]

6.26. There is no principled reason for there to be different transparency obligations across the UK. There should be alignment with the rules that apply to the UK government and the same publication obligations should apply across the UK.

Governance

6.27. Public procurement governance comprises the rules, policies and procedures that ensure that expenditure is fair, legal and delivers value for money. This includes minimising conflicts of interest and preventing corruption and maladministration.[37]

6.28. In an emergency such as a pandemic, governments and public bodies must carefully balance proper compliance with rules and regulations with acquiring healthcare equipment at the necessary speed and scale to respond. If this balance is not achieved, there may be insufficient supply and poor-quality decisions. In both cases, public confidence in the procurement system will suffer.

33 Jonathan Irvine 25 March 2025 141/12-18
34 Jonathan Irvine 25 March 2025 141/12-18, 142/7-13
35 The Public Contracts (Scotland) Regulations 2015, regulation 51 (https://www.legislation.gov.uk/ssi/2015/446/regulation/51/made); EU Directive 2014/24/EU, Annex V, Part D, para 13 (https://www.legislation.gov.uk/eudr/2014/24/annex/V); 'Scottish Procurement Policy Note SPPN 2/2024: Public procurement update – legislative and system changes', Scottish Government, 11 December 2024 (https://www.gov.scot/publications/legislative-and-system-changes-scottish-public-procurement-update-sppn-2-2024; INQ000662044)
36 INQ000539153_0045 para 133
37 INQ000539153_0015 Summary Box 3

6.29. All of the approximately 400 contracts for PPE entered into by the Department of Health and Social Care during the pandemic were through direct awards.[38] Prior to the pandemic, direct awards were rare and represented a small proportion of the contracts directly awarded by UK contracting authorities, estimated at 7% of total contract awards in the UK for 2019 and at 13% for 2020.[39]

6.30. The suspension of the usual competitive process for procurement and the speed at which procurement decisions to directly award contracts had to be undertaken meant that there needed to be a system to quickly triage and prioritise the most promising offers.

Establishment of the High Priority Lane

6.31. As the scale of the Covid-19 crisis grew and the need to source PPE became increasingly desperate, individuals and companies contacted MPs, senior officials and others in prominent positions close to the UK government to offer PPE or introductions to those who could provide it.[40] Some may have been motivated by a desire for profit, but others simply wished to help in an emergency.[41]

6.32. High-profile individuals and major companies with commercial offers and donations of PPE accustomed to dealing with high-level government representatives were disinclined to use the normal way of making offers via online portals and instead contacted ministers, MPs and officials directly.[42] Sir Gareth Rhys Williams (UK Government Chief Commercial Officer from March 2016 to July 2024) and other senior officials told the Inquiry that it would have been unrealistic to direct these suppliers to enter data into a webform in the same way as regular offers.[43]

6.33. As examined in Chapter 2: Emergency procurement and distribution during the pandemic, the PPE Cell (established by the Department of Health and Social Care in March 2020 to oversee PPE procurement and distribution) was overwhelmed with offers. There were concerns among ministers and officials that those of good quality were not being rigorously identified and processed.[44]

6.34. When ministers and senior officials in the UK government received what seemed to them to be a credible offer, they would often ask for reassurance from officials that offers were being properly processed.[45] This included letting those ministers and officials who referred such offers (and who came to be known as 'referrers') know

38 INQ000528391_0092 para 341
39 INQ000539153_0036 para 104
40 INQ000569885_0004 para 15
41 Gareth Rhys Williams 4 March 2025 206/3-9
42 INQ000536351_0007 para 4.10
43 Gareth Rhys Williams 4 March 2025 206/3-9; INQ000536351_0007, 0024-0025 paras 4.10, 7.19; INQ000534691_0012
44 INQ000531295_0026 para 91; INQ000533116; INQ000528391_0005, 0100 paras 15, 376; INQ000496857_0001
45 INQ000569885_0004 para 16

that offers were being investigated thoroughly and taken seriously.[46] This increased the workload on an already overworked procurement team.[47]

6.35. Dame Emily Lawson (National Director for Transformation and Corporate Operations at NHS England (and, from April 2018, NHS Improvement) from November 2017 to April 2020, described the offers as including those from "*people known to the PPE team*" and from "*politicians, healthcare leaders, civil servants, and others*".[48] Although attempts to direct these offers to the regular routes were made, referrers repeatedly chased and escalated the offers they had referred, creating a significant administrative burden on procurement officials.[49]

6.36. It was decided in March 2020 by Ms Lawson that the most promising of these offers should be directed to a dedicated mailbox, for them to be prioritised and for those who made the introduction to be updated on their progress.[50] The creation of this procurement route was a "*reaction*" to the circumstances.[51]

6.37. The internal system of prioritisation, which was not necessarily known about by referrers, became the High Priority and VIP Assessment Team, also known as the High Priority Lane or VIP Lane. When Max Cairnduff (High Priority Lane and Donations Lead in the PPE Buy Cell (a sub-set of the PPE Cell) from April to May 2020) was appointed to lead the team processing these offers in April 2020, he changed the team's name from the High Priority and VIP Assessment Team to the High Priority Team. He felt that the previous name gave the "*wrong impression*" and had led to the impression that a key part of the procurement response was "*effectively cronyism*", which he and others disputed.[52] It was used both for people who were considered to be important and for promising leads.[53]

6.38. It was not uncommon for suppliers to threaten officials that they would escalate their grievances to the press or ministers.[54] As Mr Cairnduff described it, the common thread was that these offers were "*potentially politically sensitive*" and were from people who would "*require greater handling*".[55] The Inquiry was told that one of the principal purposes of the High Priority Lane was to "*remove the disruption*" these referrals were causing to the rest of the PPE Cell, and this approach was believed to be "*the lesser of two evils*".[56]

46 INQ000531295_0019-0020 para 72
47 INQ000497031_0171 paras 4.391-4.396; INQ000565309_0001
48 INQ000531295_0019 para 71
49 See, for example, INQ000565128; INQ000565127_0001; INQ000565130_0001; INQ000565172_0001; INQ000565162_0001; INQ000565395; INQ000565432_0002
50 INQ000531295_0025-0026 paras 88-89
51 Andy Wood 6 March 2025 173/12-21
52 INQ000536351_0008 para 5.2; Max Cairnduff 6 March 2025 35/1-13
53 INQ000531295_0019-0020 paras 71-72
54 INQ000536369_0021 para 6.24; Chris Hall 6 March 2025 106/4-9; INQ000527557; INQ000475069_0014-0016, 0018 paras 43, 50, 61
55 INQ000531295_0026 para 91; Max Cairnduff 6 March 2025 3/22-24
56 INQ000497031_0171 para 4.396; Gareth Rhys Williams 5 March 2025 32/9-10

6.39. Procurement officials – including Mr Cairnduff, Andy Wood (Deputy Director, Commercial Specialist in the Cabinet Office and Lead for the PPE Buy Cell from March to July 2020) and Chris Hall (a manager in the PPE Buy Cell from April to June 2020) – told the Inquiry that, based on their experience, High Priority Lane offers were of a higher quality than non-High Priority Lane offers.[57]

6.40. The Cabinet Office and the Department of Health and Social Care were responsible for processing offers made through the High Priority Lane, which operated from March until May 2020.[58]

Fairness of the High Priority Lane

6.41. A fair procurement system promotes efficiency, trust and value for money by ensuring that only relevant, objective factors, such as price, quality and speed of delivery, are taken into consideration. Fairness in public procurement means that decisions on the progress and award of contracts are made only on the basis of an offer's merits. Usually, to ensure fairness and get the best value for money, there is open competition and time to consider and weigh the merits of competing offers, but in the pandemic, the speed, scale and necessity of rapid procurement and the absence of an effective system to do this meant that direct awards without competition had to be used.[59] This should not have meant that the system would operate without effective governance – only that fairness had to be applied within the pressures and confines of the pandemic.

6.42. Offers in the High Priority Lane had an advantage over offers in the non-High Priority Lane. The High Priority Lane offers were:

- given favourable treatment at the triage stage;
- likely to be progressed more quickly; and
- given a bespoke service by officials.

Favourable treatment

6.43. According to guidance issued to procurement officials, offers in the High Priority Lane were to be triaged according to different, less onerous criteria than normal offers.[60] Mr Cairnduff told the Inquiry that there was a belief among those carrying out procurement of PPE that:

> "*contacts coming through the* [High Priority Lane] *would be of good quality and would lead to credible offers of PPE*".[61]

57 INQ000536351_0014 para 6.2; INQ000540488_0005 para 3.3; Chris Hall 6 March 2025 133/2-22
58 INQ000536351_0004-0005, 0034 paras 4.1, 7.45; INQ000528391_0099-0103 paras 373-386
59 Gareth Rhys Williams 4 March 2025 174/13-25
60 INQ000551580_0015; Jonathan Marron 5 March 2025 180/13-18; INQ000534702_0022
61 INQ000536351_0006 para 4.5

6.44. Analysis of the evidence of the referrers whose offers were put into the High Priority Lane and the suppliers awarded contracts suggests that nearly two-thirds of referrers did not conduct checks on the suppliers.[62] While referrers might have thought suppliers had some credibility owing to a personal knowledge of them, they – and the officials to whom they referred the offers – generally had no objective reason to think that the suppliers would, in fact, be able to supply the necessary PPE. There was no good reason to conclude that, because the referrer of an offer was believed to be credible, it followed that the offer itself was credible.

6.45. The assumption that offers in the High Priority Lane were credible arose because undue weight was attached to the identity, status and authority of the referrer, rather than any inherent quality of the offer.[63] Mr Cairnduff said that, at the time, he believed that an offer in the High Priority Lane "*with merit should be given priority over a case of equal merit which came from another route*".[64] In an email in April 2020, he said: "[I]*f two leads are otherwise equal priority and one is VIP, some weighting to the VIP is helpful.*"[65] The suggestion was rejected by the PPE Cell's technical assurance team. Mr Cairnduff acknowledged to the Inquiry that, on reflection, he was simply wrong. He explained that he was "*buried in an ocean of cases*" and had "*lost perspective*".[66]

Offers likely to be progressed more quickly

6.46. According to Mr Wood, it was the view of Theodore Agnew, Lord Agnew of Oulton (Minister of State at the Cabinet Office and the Treasury from February 2020 to January 2022, whose role included procurement) that procurement officials "*needed to be able to quickly respond to the credible offers that were coming in through senior people*".[67]

6.47. The High Priority Lane team triaged what were assumed to be credible offers on a "*fast track*", compared with non-High Priority Lane offers.[68] The initial contact with suppliers in the High Priority Lane aimed to be within 24 hours and this helped them to "*get on the ladder*".[69] The faster an offer could be progressed through the procurement system, the better the chances were of securing a contract.[70] Mr Hall told the Inquiry that being in the High Priority Lane "*probably got you to Technical Assurance … more quickly*".[71]

62 This is based on analysis of 35 High Priority Lane referrers who provided statements to the Inquiry, 33 of whom provided relevant evidence. See INQ000660263; INQ000540488_0022 para 4.1c
63 INQ000536362_0025-0026 para 75; Gareth Rhys Williams 5 March 2025 10/9-12, 11/16-19; Andrew Feldman 12 March 2025 207/16-208/19
64 INQ000536351_0023 para 7.16
65 INQ000498255_0001
66 Max Cairnduff 6 March 2025 13/2-13
67 INQ000540488_0027-0028 para 5.12; Andy Wood 6 March 2025 175/15-176/25
68 INQ000540488_0027-0028 para 5.12; INQ000534911_0001
69 Max Cairnduff 6 March 2025 56/7-19
70 Max Cairnduff 6 March 2025 48/6-10, 52/15-20; INQ000477274_0002
71 Chris Hall 6 March 2025 144/11-12

6.48. Analysis of the evidence of the referrers whose offers were put into the High Priority Lane and the suppliers awarded contracts suggests that more than half of referrers made contact for updates on the progress of offers.[72] Dame Emily Lawson thought it would have been "*fundamentally unprofessional*" not to provide updates to such referrers.[73] The effect of this contact was to push along suppliers that had been referred into the High Priority Lane – a benefit which was not available to non-High Priority Lane offers.

6.49. According to the guidance given to procurement officials, offers more than two weeks old were generally not considered to be credible owing to market volatility, and so getting ahead of a delay in initially processing an offer was a significant advantage. In many cases, it made non-High Priority Lane cases "*less likely*" to get to the contract stage.[74] The technical assurance stage created "*serious bottlenecks*" in the procurement process but, if an offer was in the High Priority Lane, it received attention from a specialist team. This sped up the processing of these offers even further by affording them priority.[75]

Bespoke service

6.50. Between March and June 2020, when the procurement of PPE was at its most frenetic, offers were frequently incomplete and there was a complex, iterative process to awarding a contract (see Chapter 2: Emergency procurement and distribution during the pandemic). Against this backdrop, offers in the High Priority Lane were:

> "*given full care in terms of feedback and communication – in a way that could not be guaranteed to all the suppliers in the general lane*".[76]

6.51. Although, once triaged, offers in the High Priority Lane went through "*exactly the same*" 'end-to-end' procurement process examined in Chapter 2: Emergency procurement and distribution during the pandemic and were subject to the same due diligence as non-High Priority Lane offers, there were some key differences in how they were handled. Offers in the High Priority Lane were given "*face time*" by officials, had a dedicated caseworker and were prioritised over regular offers.[77] It was likely that a supplier with a low-quality offer in the High Priority Lane would receive more contact with officials than an offer in the non-High Priority Lane.[78] As it was put in an email in April 2020 about High Priority Lane offers:

72 This is based on analysis of 35 High Priority Lane referrers who provided statements to the Inquiry, of whom 33 responded with relevant information. See INQ000660263; INQ000540488_0022 para 4.1c
73 Emily Lawson 11 March 2025 40/14-41/21
74 Chris Hall 6 March 2025 145/4-5
75 Max Cairnduff 6 March 2025 48/12-16; INQ000569885_0004-0005 para 18; Chris Hall 6 March 2025 144/13
76 INQ000540488_0033 para 7.4
77 Darren Blackburn 6 March 2025 71/11-20, 72/8-18
78 INQ000540488_0033-0034 para 7.6

> "*Cabinet Office are keen that they receive a speedy response from us in terms of taking their potential offers of support forward.*"[79]

6.52. As they generally received a faster response and more feedback from officials, suppliers in the High Priority Lane were given an unjustified advantage. The faster response allowed them to get ahead of other potential offers and the feedback enabled them greater opportunity to perfect their initial offers and so increase the prospects of securing a valuable contract.

The impact of the High Priority Lane

Likelihood of being awarded a contract

6.53. Suppliers in the High Priority Lane were approximately 13 times more likely to be awarded contracts than non-High Priority Lane suppliers (see Table 1).[80]

Table 1: Comparison of contracts awarded

Workstream	Number of suppliers who offered PPE	Number of suppliers awarded contracts	Supplier award rate
High Priority Lane	430	54	13%
Non-High Priority Lane	15,194	160	1%

Source: INQ000587343_0001 para 4; INQ000613602

6.54. The testing programme (discussed below) had its own, separate system for prioritising offers which, similarly to the High Priority Lane for PPE, sorted offers referred by a politician or senior government official into a 'priority' mailbox, along with other promising offers.[81] In a review of success rates, the UK Health Security Agency found that the proportion of suppliers awarded a contract out of the total offers provided was 16% for offers in its 'priority' mailbox, compared with between 5.4% and 7.3% of offers in non-priority mailboxes.[82] Offers for testing equipment processed via the UK Health Security Agency's priority mailbox were much more likely to lead to contracts than those processed via its non-priority mailbox.[83]

79 INQ000565104_0001; see also INQ000531295_0025 para 88
80 INQ000660160_0004 Table 5. Supplier award rates calculated by (number of High Priority Lane (HPL) contracts awarded / number of HPL suppliers) and (number of non-HPL contracts awarded / number of non-HPL suppliers).
81 Sarah Collins 13 March 2025 83/4-87/4
82 INQ000383567_0011-0013
83 INQ000383567_0013 para 28; INQ000521972_0059 para 4.193

6.55. Sarah Collins (Commercial Director at the UK Health Security Agency from January 2022 to January 2025) explained that the agency's investigations concluded that priority offers went through a process of rigorous scientific evaluation and were processed in the same way as non-priority offers.[84] However, no witness was able to explain why an offer for testing equipment should be inherently more credible because it was connected to a politician or senior government official.

Risk of bias and suspicion

6.56. The existence of the High Priority Lane for PPE was made known initially only to:

- senior officials, including Sir Gareth Rhys Williams, Ms Lawson and Jonathan Marron (Director General at the Department of Health and Social Care from June 2017 to July 2025); and
- ministers and special advisers to the UK government, including Michael Gove MP, later Lord Gove (Chancellor of the Duchy of Lancaster from July 2019 to September 2021 and Minister for the Cabinet Office from February 2020 to September 2021), Mr Hancock, Lord Agnew and James Bethell, Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021).[85]

6.57. Andrew Feldman, Lord Feldman of Elstree (a volunteer for the Department of Health and Social Care), had a special position within the UK government to act as an envoy with "*near enough quasi-ministerial status*" and used his business contacts to assist with sourcing PPE.[86] Although he was unaware during his time as a volunteer of the existence of the High Priority Lane, suppliers he referred to procurement officials were processed within it.[87]

6.58. If a potential supplier happened to have a connection with the individuals to which the High Priority Lane was initially promoted – whether party political, through friendship or otherwise – they had an advantage over those who did not. As the ministers and special advisers had, by definition, some affiliation with the governing Conservative Party, it increased the likelihood that offers from those with connections to them – and by implication the party – would be referred into the High Priority Lane. This conferred the benefits of speed, a bespoke service and the increased likelihood of being awarded a contract. Sir Gareth Rhys Williams told the Inquiry that, as most referrals came from ministerial offices, this was "*no surprise*".[88]

84 Sarah Collins 13 March 2025 93/4-25
85 INQ000536351_0006, 0010 paras 4.6, 5.7; INQ000534685; INQ000498249; Max Cairnduff 6 March 2025 37/14-24; INQ000497031_0172 para 4.398
86 Max Cairnduff 6 March 2025 38/4-23; Chris Hall 6 March 2025 118/13-20
87 INQ000540486_0003-0004 paras 8-9
88 Gareth Rhys Williams 5 March 2025 41/2-8

6.59. Mr Cairnduff credited the success of some offers referred into the High Priority Lane to Lord Feldman's work and his belief that reputable companies with credible offers would approach ministers directly.[89] Mr Hall told the Inquiry that offers presented to him by Lord Feldman, which contained information about a supplier's connection to the Conservative Party, were taken by him to mean that Lord Feldman "*had some confidence that the counterparty was credible*".[90] Lord Feldman explained that he used his "*experience and commercial judgment to assess the credibility of any offers*".[91] This expertise was useful, and in a future pandemic such help should be encouraged. However, the Department of Health and Social Care should have ensured that there were appropriate checks and balances to make sure that all offers were being triaged according to the same criteria, irrespective of their source.

6.60. Of the 36 referrers of successful offers into the High Priority Lane, 15 had a connection with the Conservative Party. No other political party was represented in the other 21 suppliers awarded contracts.[92] However, the High Priority Lane was not limited to those with connections to the Conservative Party. Offers from Labour and Liberal Democrat MPs, trade union officials and a wide range of other sources were referred to the High Priority Lane in the same way as offers referred by those who happened to have a connection with the Conservative Party.[93] For example, Rachel Reeves MP (Shadow Minister to the Cabinet Office from April 2020 to May 2021) made a referral of approximately 20 suppliers to Mr Gove, who duly referred the offers on to officials, asking for them to be looked at "*closely*".[94] These were examined and ultimately rejected by officials as being unsuitable.[95]

89 Max Cairnduff 6 March 2025 8/11-8/24
90 Chris Hall 6 March 2025 120/3-19, 124/19-23
91 INQ000540486_0002-0003 para 5
92 This is based on analysis of 35 High Priority Lane referrers who provided statements to the Inquiry, 33 of whom provided relevant evidence. See INQ000660263
93 INQ000565128; INQ000565127_0001; INQ000565395; INQ000565130_0001
94 Michael Gove 10 March 2025 162/12-13
95 INQ000581859_0002-0003 paras 7-13; INQ000563560_0017-0018 paras 62-63; INQ000528589; INQ000551356; INQ000512941; Chris Hall 6 March 2025 110/10-21

Case study: Meller Designs Ltd

Meller Designs Ltd was a company involved in the fashion industry.[96] Its owner, David Meller, was a "*great personal friend*" of Mr Gove and, in 2016, supported Mr Gove's campaign for the leadership of the Conservative Party with a donation of £3,250.[97]

On 19 March 2020, Mr Meller emailed Mr Gove's private office to ask whether the UK government was interested in PPE his company had been offered, and Mr Gove's private office forwarded the email to officials.[98] Having had no response, Mr Meller again contacted Mr Gove's private office, which again forwarded the emails on to officials.[99]

On 26 March 2020, Mr Meller spoke with Mr Gove and Lord Agnew about his company's offers to supply PPE and the continued lack of a response.[100] While Mr Gove did not personally enquire into or monitor whether Meller Designs Ltd had been awarded any contracts, he asked his team to ensure that any offers were being followed up and considered.[101] As it was a task for procurement officials, Mr Gove did not perform any checks on Meller Designs Ltd.[102] He regarded it as a serious potential supplier and was concerned that the procurement system was working slowly or inefficiently.[103]

The fact that the offer had come through the High Priority Lane and had the attention of Mr Gove appeared in procurement documents. For example, in an email from Lord Feldman to procurement officials, Mr Meller was referred to as a good friend of Mr Gove and, in contemporaneous documents between procurement officials, Mr Meller was described as very well connected, the offer was referred to as "*high profile*", a "*VIP*" request, and it was observed that Mr Meller had "*Michael Gove's ear*".[104]

Meller Designs Ltd was awarded seven contracts for PPE totalling approximately £164 million.[105]

6.61. Mr Gove told the Inquiry that he had "*no influence whatsoever*" and "*no minister took decisions to award contracts*".[106] However, having a connection with someone in the UK government or the Civil Service did result in offers in the High Priority Lane being

96 INQ000563560_0022 para 83
97 INQ000563560_0022 para 84; Michael Gove 10 March 2025 157/4
98 INQ000563560_0019 para 69; INQ000563687; Michael Gove 10 March 2025 158/7-13
99 INQ000563560_0019 paras 70-71; INQ000563685; INQ000563686; INQ000563691
100 INQ000563560_0019-0020, 0022 paras 72, 82; INQ000563694; INQ000563695
101 INQ000563560_0023 para 87
102 INQ000563560_0022-0023 para 85
103 INQ000563560_0020 paras 73-74
104 INQ000533868_0004; INQ000534695_0001; INQ000533988_0001; INQ000519007; INQ000519042; INQ000519066_0004, 0011-0013; INQ000534834_0001
105 INQ000613602 rows 120-124, 274, 286
106 INQ000563560_0018 para 65; INQ000563560_0020, 0023 paras 73, 87-89

treated differently from non-High Priority Lane offers. Otherwise, there could be no purpose in referring to the source of the referral – for example, a connection with a minister – in procurement documents. It should have been obvious that the creation of a parallel triage system likely to favour those with connections to the government embedded unfairness in procurement.[107]

6.62. The correlation between referrers having connections with the UK government or the governing party and the award of contracts gives at least an appearance of bias. Although there is no evidence that it was by design, the appearance of bias must be avoided in future if the emergency procurement system is to command public confidence.

The performance of the High Priority Lane

6.63. According to data supplied to the Inquiry by the Department of Health and Social Care, non-High Priority Lane contracts in the PPE Cell outperformed High Priority Lane contracts in a number of areas, including:

- procuring directly from manufacturers;
- price; and
- contract performance.

Procuring directly from manufacturers

6.64. In general, intermediaries in a supply chain between manufacturers and purchasers increase prices for end-users, as each intermediary seeks to add value and thus make a profit on the items it buys and sells. The more intermediaries there are in a supply chain, the greater the likelihood that prices will be higher.[108]

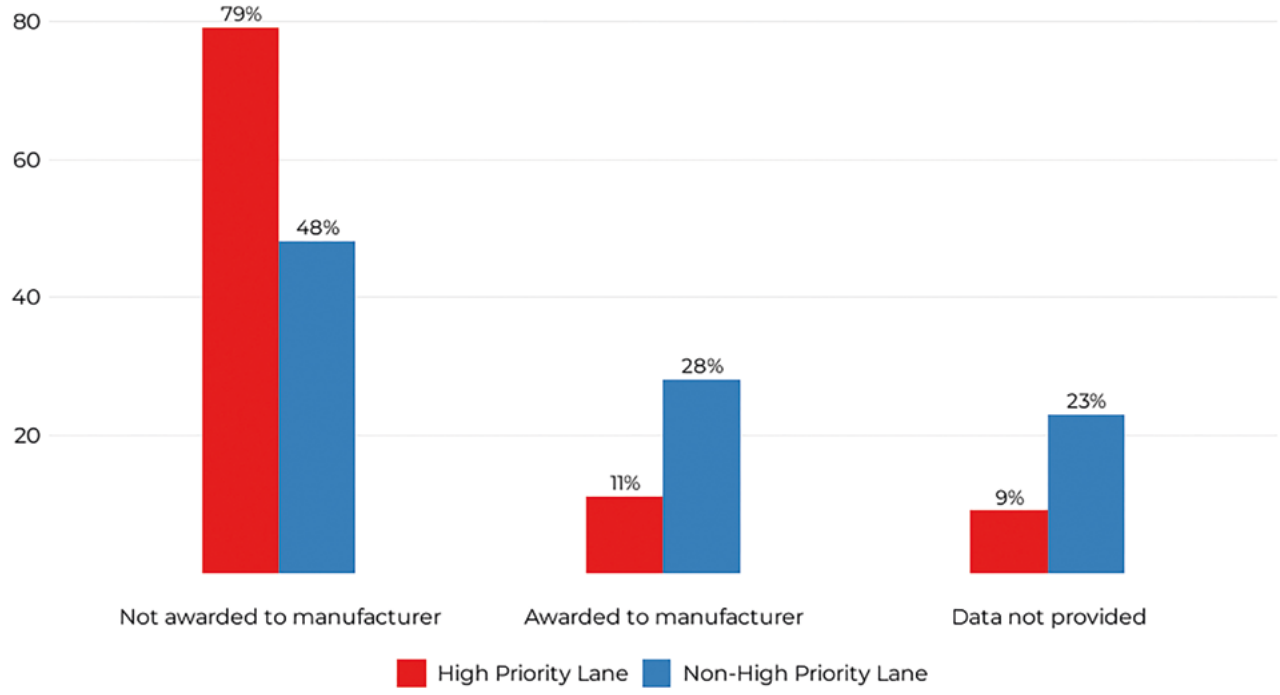
6.65. Officials were aware of this during the Covid-19 pandemic and also knew that, generally, the closer they were to a manufacturer, the greater the "*security*" and "*confidence*" they could have in an offer.[109] This was due to buyers having better visibility over the stock they were purchasing and the manufacturer's production capabilities compared with the potentially more "*fragile*" supply chains involving intermediaries.[110]

6.66. For these reasons, an emergency procurement system would normally seek to purchase as closely to manufacturers as possible.[111] However, analysis of the available data provided by the Department of Health and Social Care suggests that, in the High Priority Lane, the opposite was true: 11% (13) of contracts were awarded

107 Max Cairnduff 6 March 2025 38/19-40/5
108 INQ000474864_0014-0015 para 64
109 Simon Manley 10 March 2025 101/16-102/17; Jonathan Marron 5 March 2025 203/1-10, 204/2-5
110 INQ000474864_0156 para 695
111 INQ000474864_0156-0157 paras 695-697

directly to manufacturers, compared with 28% (73) of contracts outside the High Priority Lane (see Figure 13).[112] If that is the case, the High Priority Lane favoured and rewarded intermediaries more than those outside it, thereby increasing the likelihood of higher prices and decreasing the security and confidence in the supply.

Figure 13: Contracts awarded to manufacturer by High Priority Lane status (%)



Source: INQ000660160_0006 Table 9. Data limitations necessitate a cautious interpretation of these findings. Significant portions of the contract data are incomplete, specifically regarding award status. Missing information affects 9% of High Priority Lane contracts and 23% of non-High Priority Lane contracts. However, while the missing data do not preclude the identification of broad comparative trends between workstreams, they diminish the precision of the calculated differences.

6.67. Mr Marron told the Inquiry that the use of intermediaries was "*necessary*" to secure PPE in a challenging market and that, although it was not an optimal approach, over time, the PPE Cell did get closer to procuring directly from manufacturers.[113] The reason the Department of Health and Social Care relied on intermediaries was that they:

> "*had a better understanding of the global PPE market and the logistics of delivering PPE to the UK*".[114]

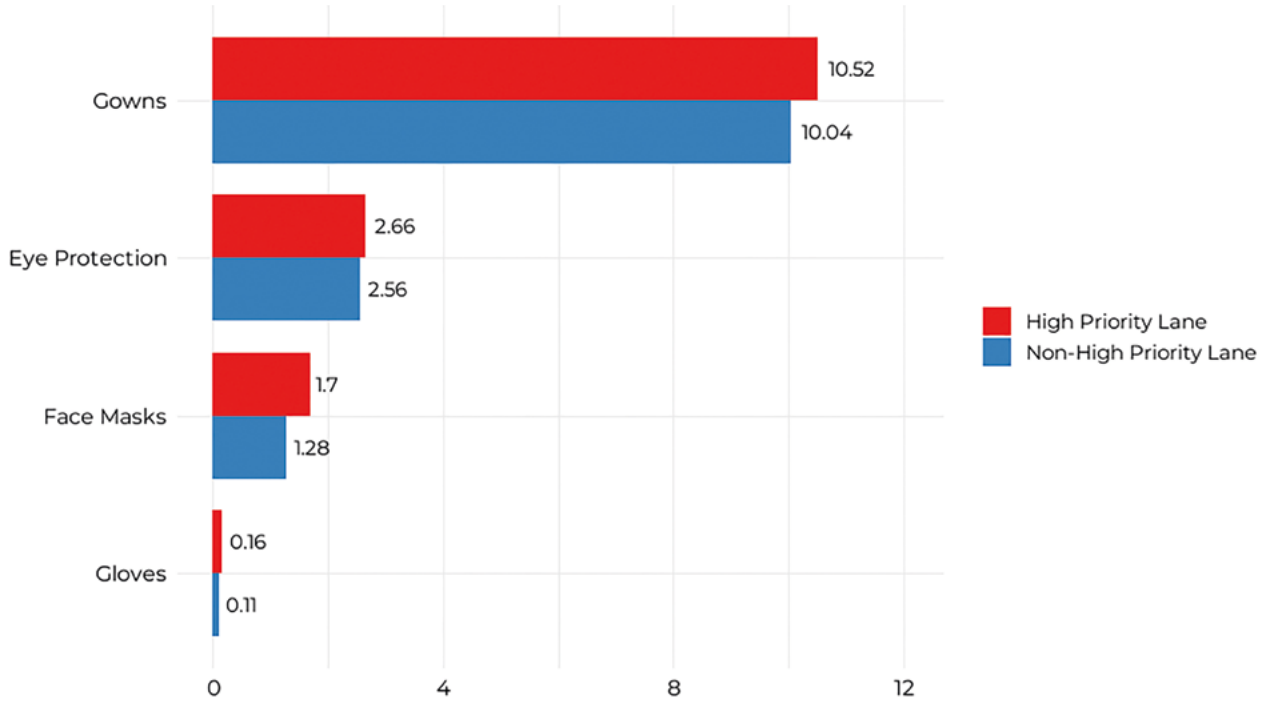
Intermediaries such as suppliers in the High Priority Lane used the information advantage they had over the Department of Health and Social Care and expected to be remunerated for it.

112 INQ000565970_0024; INQ000660160_0006 Table 9
113 Jonathan Marron 5 March 2025 203/6-204/8
114 INQ000528391_0126 para 464

Price

6.68. Analysis of the available data provided by the Department of Health and Social Care suggests that the average unit prices of each type of PPE were higher in the High Priority Lane compared with non-High Priority Lane contracts (see Figure 14).[115]

Figure 14: Average unit price for single-item PPE contracts by High Priority Lane status (£), 2020 to 2021



Source: INQ000660160_0003 Table 4. PPE unit cost estimates are subject to uncertainty. The analysis is limited to a reduced sample size of 262 single-item contracts, excluding 24 multi-item agreements where unit prices were unknown. Undocumented variables such as product specification, market fluctuations and ancillary costs (logistics and insurance) are not accounted for and may influence the final estimates.

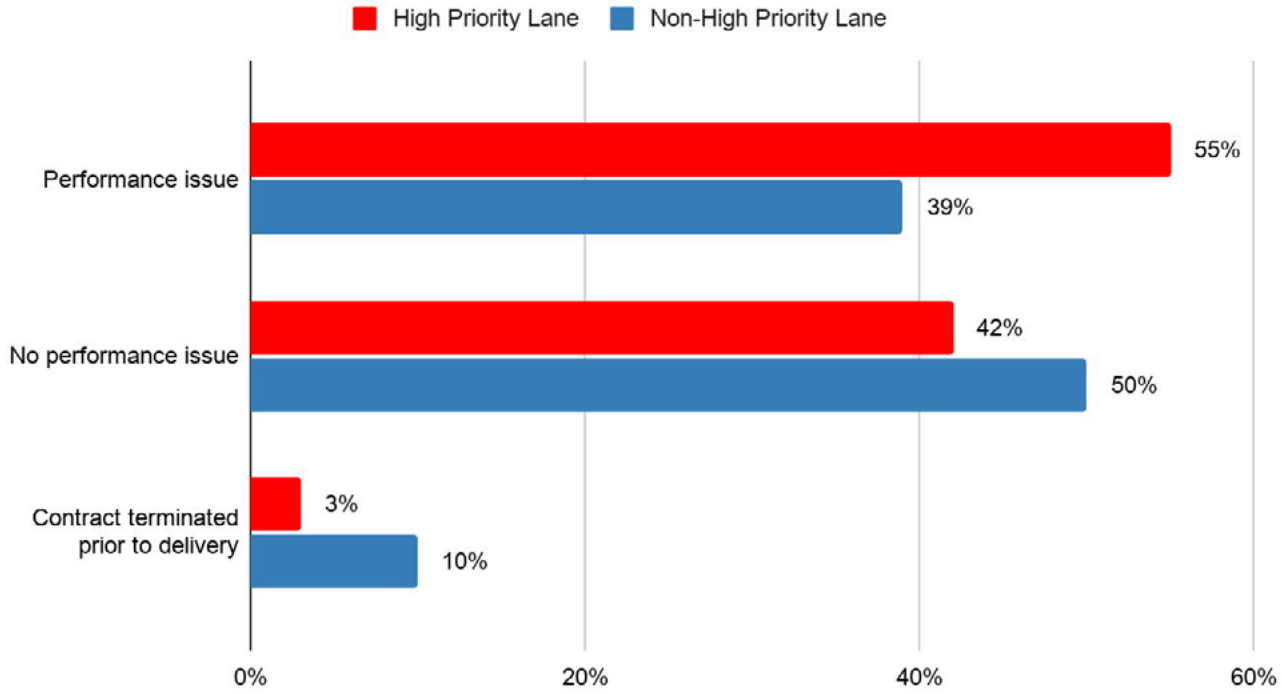
6.69. As Mr Marron observed, these data had to be treated with caution. They did not account for certain factors, such as contracts where more than one type of PPE was being supplied, different specifications of PPE categorised together, the dates of the contracts or the speed of delivery. Each factor might have had an effect on the prices being paid.[116] However, the data are consistent with offers in the High Priority Lane being more likely to be made through intermediaries and being accepted earlier in the Covid-19 pandemic, both of which would also result in higher prices. As Mr Marron told the Inquiry, High Priority Lane or not, "*we accepted that we would pay higher prices in order to secure the PPE that we needed*".[117]

115 INQ000660160_0003 Table 4
116 Jonathan Marron 5 March 2025 204/9-206/9
117 Jonathan Marron 5 March 2025 206/5-9

Contract performance

6.70. Analysis of the available data provided by the Department of Health and Social Care suggests that proportionally more High Priority Lane contracts than non-High Priority Lane contracts were judged by the Department of Health and Social Care to have had issues with contractual performance (see Figure 15). Issues ranged from incorrect technical documents to the supply of the wrong type of equipment.[118]

Figure 15: Contracts with performance issues by High Priority Lane status (%), 2020 to 2021



Source: INQ000660160_0002 Table 1. The analysis is missing performance status information for 3% of High Priority Lane contracts and 10% of non-High Priority Lane contracts. Given the relatively low levels of missing data, the broad comparative differences between workstreams are likely to be accurate; however, the incomplete data diminish the precision of the calculated differences.

6.71. Whether a supply of healthcare equipment came through the High Priority Lane or not, officials were generally unable to check the quality of the healthcare equipment being procured until it arrived within the UK and so, unless an issue could be resolved immediately, equipment was held back pending further investigations.[119] Once checks had been completed and any issues resolved, approximately 40 contracts (comprising 21 High Priority Lane and 19 non-High Priority Lane contracts) were found to have a quality issue.[120] The level of waste in procurement across the UK is examined in Chapter 7: Data, technology and the future of emergency procurement.

118 INQ000613602; Jonathan Marron 5 March 2025 198/21-199/15
119 INQ000528391_0162-0163 para 604; Jonathan Marron 5 March 2025 130/17-131/6; INQ000339320
120 Jonathan Marron 5 March 2025 130/16-131/6, 195/24-196/15, 197/7-21, 198/21-199/15, 200/15-19

6.72. However, it took until June 2023 for these checks to be completed.[121] Therefore, at the height of the pandemic, when it mattered the most, this PPE could not be immediately distributed to the front line of the health and social care sectors. Whatever the final result of the Department of Health and Social Care's checks in the fullness of time, issues with contractual performance resulting in notices not to supply equipment were greater with High Priority Lane than non-High Priority Lane contracts.

Allocation of resources to the High Priority Lane

6.73. At its height, the PPE Cell was staffed by approximately 508 officials and, of these, 38 were working on the High Priority Lane.[122] As the High Priority Lane team was handling cases from influential referrers and suppliers, who were likely to apply greater pressure and, it was believed by officials, were more likely to have better offers, it was staffed by those with greater procurement experience.[123] As these officials were not available to process non-High Priority Lane offers, there was an "*opportunity cost*" in that the progress of these offers was delayed.[124] The issue was recognised in April 2020 in a PPE buying update, which recorded:

> "*VIP escalation is obstructing progress of more viable opportunities for larger/ scalable manufacturers.*"[125]

6.74. Mr Hall and Mr Cairnduff told the Inquiry that, based on their experience, offers in the High Priority Lane were higher value, larger and more credible than non-High Priority Lane offers.[126] High Priority Lane contracts made up 31% (117) of the total number (374) of contracts awarded by the Department of Health and Social Care for PPE and accounted for 49% (£4.2 billion) of the total amount spent by the department on PPE.[127] Mr Hall cited the success of individual contracts in the High Priority Lane, told the Inquiry that there was a "*really big qualitative difference*" between High Priority Lane offers and non-High Priority Lane offers, and suggested that this might explain the apparent advantage of being in the High Priority Lane.[128] As he put it, "*the advantage accrues from the nature of the offers in the queue*".[129]

6.75. However, the evidence suggests that High Priority Lane contracts were more expensive, less likely to be with manufacturers and had more contract performance issues than non-High Priority Lane contracts. The data about the contracts awarded could and should have been analysed and available to ministers and procurement officials. By allowing subjective and irrelevant criteria – such as the identity, status

121 INQ000528391_0228 para 860
122 INQ000497031_0151 para 4.320; INQ000477253_0001
123 INQ000540488_0033 para 7.4; INQ000536351_0004 para 3.5; Chris Hall 6 March 2025 100/24-101/11, 103/3-7; INQ000536351_0006-0007 paras 4.8-4.9; INQ000533339_0012-0015; Darren Blackburn 6 March 2025 69/12-23
124 Max Cairnduff 6 March 2025 31/12-19; INQ000540488_0033 para 7.4; INQ000536351_0005 para 4.2
125 INQ000339149_0004
126 Chris Hall 6 March 2025 132/19-133/24; Max Cairnduff 6 March 2025 8/8-9/5
127 INQ000660160_0004_0005 Tables 6, 8
128 Chris Hall 6 March 2025 133/23-24, 145/16-18
129 Chris Hall 6 March 2025 150/11-12

and authority of the referrer – to carry weight, the High Priority Lane meant that resources were allocated away from other credible offers. This offended the principle of fairness that procurement officials otherwise sought to uphold during the pandemic.

The role of high priority lanes in emergency procurement

6.76. Ministers and officials understandably did not want to risk losing what were believed to be credible offers in an extremely competitive market on account of an overly rigid adherence to governance processes.

6.77. Given how the High Priority Lane was later perceived, it is ironic that it stemmed from the desire of officials to triage and process quickly what they thought to be credible offers and to maintain public confidence in the PPE procurement process.[130] It did the opposite of maintaining public confidence and undermined the extraordinarily hard work of procurement teams generally to procure PPE and other healthcare equipment.[131]

6.78. There was no equivalent to the High Priority Lane in the devolved administrations or, as far as Professor Albert Sanchez-Graells (expert witness on public procurement during emergencies) was able to determine, in any other country.[132] It was unique to the UK government. In 2022, the High Priority Lane was challenged in the High Court and judged to be unlawful as it breached the requirement of equal treatment of offers.[133]

6.79. The use of a system of prioritisation for those with connections to ministers and officials was not limited to PPE procurement. Lord Bethell described in a note to parliamentarians that he could similarly "*fast track*" especially promising offers for testing equipment.[134] Emailed offers to supply testing equipment were forwarded to procurement officials' inboxes and, if they were associated with a minister or MP, they were marked "*Priority/Fast track*".[135]

6.80. In a parliamentary democracy such as the UK, direct contact with parliamentarians is to be expected and there should not generally be any interference with this right. It is also the duty of ministers to exercise oversight over officials' activity. However, parliamentarians, special advisers and officials not involved in procurement should not have any role in the progress or award of specific contracts.[136] In the event of receiving offers to supply healthcare equipment, the procurement system should ensure that each offeror:

130 INQ000531295_0026 para 91; INQ000527634_0004, 0151-0152 paras 6-7, 369; Darren Blackburn 6 March 2025 68/22-69/2
131 Jonathan Marron 5 March 2025 182/3-8; Chris Hall 6 March 2025 103/11-16
132 INQ000539153_0144, 0151 paras 345, 372
133 INQ000534910
134 INQ000551339_0007
135 INQ000521972_0042 para 4.99
136 Max Cairnduff 6 March 2025 16/7-17/2

- receives a standardised response explaining that the emergency procurement process is the same for all and is insulated to guard against potential outside interference;
- is directed to an emergency procurement portal; and
- is directed to refrain from contacting procurement officials to enquire into or progress offers.[137]

6.81. No witness gave evidence that they would repeat the experiment of the High Priority Lane. While there needed to be some form of prioritisation of offers, it was clearly the wrong approach.[138] As Mr Hall told the Inquiry:

> "[T]*he mere fact of being referred by a senior figure, in particular by a politician, is* [not] *an adequate means of prioritisation.*"[139]

6.82. The Inquiry found no evidence of cronyism or corruption on the part of ministers or officials in the final decision of whether to award or reject a contract. However, the operation of the High Priority Lane created an unfairness within the UK government's emergency procurement. Although it was not intended, the system was inherently biased towards those with connections to the UK government. This heightened the risk of abuse. It damaged the reputation of those involved in procurement during the pandemic and undermined public trust in the UK government's emergency procurement system, in the UK government itself and in its response to the pandemic.[140] The High Priority Lane should not be repeated.

Accountability

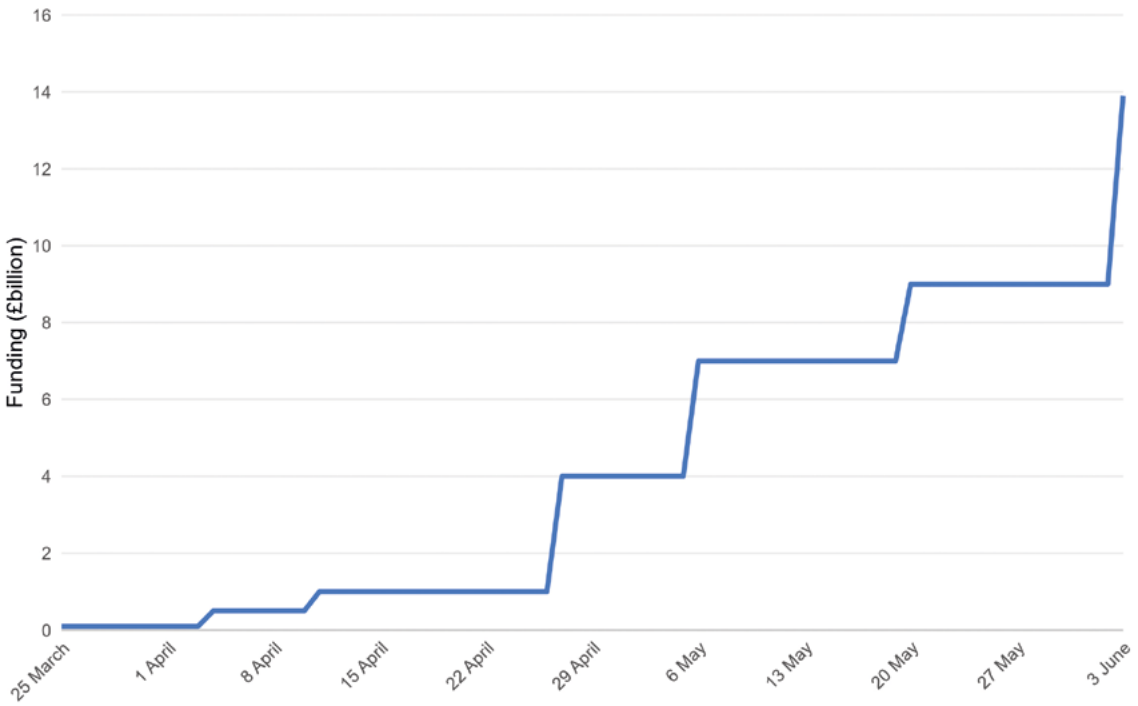
6.83. Effective accountability is being able to identify clearly who or what entity is responsible for key decisions – such as in spending public money – in order to apply effective scrutiny and challenge decisions where appropriate.[141] In the UK government, the Treasury sought to monitor and control spending by:

- imposing a condition that reasonable attempts be made to ensure that the prices paid for PPE were not more than 25% above the average price paid at the time;
- ensuring that the Department of Health and Social Care's accounting officers scrutinised each payment; and
- requesting a weekly update on purchases and prospective purchases tracked against demand.[142]

137 INQ000539153_0102-0103 para 292.2
138 Max Cairnduff 6 March 2025 32/8-33/16; Jonathan Marron 5 March 2025 182/6-8; Darren Blackburn 6 March 2025 83/10-84/24
139 Chris Hall 6 March 2025 113/15-22
140 Jonathan Marron 5 March 2025 182/3-8; Chris Hall 6 March 2025 103/11-16
141 INQ000539153_0020 para 51
142 Stephen Barclay 12 March 2025 104/23-105/5; INQ000273559; INQ000521966_0064

6.84. Notwithstanding these attempts to control spending on healthcare equipment, expenditure increased rapidly over the course of the pandemic.[143] There was a 138-fold rise from £100 million to £1.38 billion in the funding granted by the Treasury to the Department of Health and Social Care for PPE between March and June 2020 (see Figure 16).

Figure 16: Additional funding allocated to the Department of Health and Social Care for PPE, 25 March 2020 to 3 June 2020



Source: INQ000528391_0150-0155 paras 555-566

Key issues with managing public money

6.85. Stephen Barclay MP (Chief Secretary to the Treasury from February 2020 to September 2021) explained that the Treasury needed to make quick decisions throughout the Covid-19 pandemic, often on the basis of uncertain and incomplete information. It needed to balance value for money with the flexibility needed to meet the urgent spending required for the health response.[144] The spread of the pandemic was unpredictable and it was difficult to calculate with precision the effect, for example, of novel strains of the virus, non-pharmaceutical interventions and the vaccination programme on demand for healthcare equipment.[145] As Mr Barclay told the Inquiry, this created "*huge uncertainty*" over spending.[146]

143 Stephen Barclay 12 March 2025 102/13-22; INQ000521966_0023 para 63
144 INQ000574180_0003-0004 paras 11, 15
145 INQ000528391_0114 para 423
146 Stephen Barclay 12 March 2025 112/17-113/5; INQ000521966_0007 para 15

6.86. The principal issues for the Treasury and the Department of Health and Social Care were:

- their differing approaches to managing risk;
- the "*siloing*" (or limited sharing) of data between the two departments;[147]
- an inconsistent application of spending conditions for PPE; and
- the need for exceptional spending on special projects in the Ventilator Challenge and NHS Test and Trace.

The issues between the Treasury and the Department of Health and Social Care examined below were not experienced by the equivalent bodies in the devolved administrations. The experiences of the two departments nonetheless demonstrate the general importance across the UK of having an effective system to monitor and control spending on healthcare equipment in a pandemic.

Managing risk

6.87. There will always be a tension between the demands of a spending department and the Treasury. In a health emergency, the tension between the lead government department – the Department of Health and Social Care – and the Treasury was bound to emerge. Each had different and evolving approaches to risk and spending controls.[148] While the Department of Health and Social Care intended to acquire PPE at nearly any cost, the Treasury was generally more risk-averse and tried, with mixed success, to apply more stringent spending controls.[149] Chris Young (Director of Finance at the Department of Health and Social Care from August 2017 to October 2021) explained that, despite attempts by officials to find common ground, the risk appetite of the Treasury was "*not always aligned*" with that of Boris Johnson MP (Prime Minister from July 2019 to September 2022) or Mr Hancock.[150]

6.88. Mr Barclay acknowledged that "*spending increased extremely quickly*" and that, while "*value for money changes at a time of national crisis*", there were limits to the flexibility the Treasury was willing to grant to the Department of Health and Social Care in procurement.[151] Mr Hancock explained that, although he encouraged officials in the Department of Health and Social Care and the Treasury to continue to work together, due to the scale of the procurement emergency he was content to approve expenditure by the Department of Health and Social Care outside of some of the formal limits.[152]

147 Stephen Barclay 12 March 2025 114/11-115/9
148 INQ000521966_0008-0010 paras 20-23
149 INQ000574180_0009-0010
150 INQ000563070_0020 para 80
151 Stephen Barclay 12 March 2025 102/17-18, 107/2-3
152 INQ000563350_0023-0025 paras 99-107; Matt Hancock 19 March 2025 109/18-20, 111/18-113/7

6.89. In December 2020 and January 2021, for example, the Treasury refused retrospective requests from the Department of Health and Social Care totalling approximately £677 million for PPE warehousing and logistics, £13 billion for PPE and £400 million for ventilator purchases, as well as additional spending on testing and vaccines. This resulted in irregularities being recorded in the Department of Health and Social Care's accounts and undermined the financial integrity and credibility of some of the key spending decisions taken during the emergency.[153] As Mr Barclay explained, he was unwilling, against a "*wider background of … unapproved spending*" by the Department of Health and Social Care, to approve its approach.[154]

6.90. The Treasury is usually the last line of scrutiny before UK government spending is committed. This is a vital role but, to prepare for a pandemic, the Treasury must work together with key government departments, such as the Department of Health and Social Care, to plan and orchestrate spending in critical areas. This includes the procurement of key healthcare equipment. A clearer agreement between the Department of Health and Social Care and the Treasury at the outset of the emergency procurement of healthcare equipment in March 2020 about how spending risks would be managed would have improved the process. It would also have increased public confidence that expenditure during the pandemic was subject to adequate scrutiny and controls. New Treasury guidance on spending controls in a crisis, scheduled to be published in 2026, should aim to address these issues.[155]

Poor communication and sharing of information

6.91. Notwithstanding the ongoing dialogue with the Department of Health and Social Care, the Treasury considered that the department failed to provide it with sufficient information about its spending plans for procurement in sufficient time for the Treasury to apply proper scrutiny.[156]

6.92. Mr Barclay explained that gaps – for example, in PPE inventory data and usage rates – meant that procurement and expenditure decisions were made in a "*highly uncertain environment*".[157] When requests came to the Treasury to approve spending at short notice, neither the Treasury nor the Cabinet Office officials who possessed the expertise to scrutinise and potentially to improve contracts had the opportunity to do so.[158]

6.93. On a number of occasions, the Treasury was "*asked for very large spending decisions with very, very little time*".[159] For example:

153 INQ000574180_0009-0010
154 INQ000574180_0010
155 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, p20 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)
156 Stephen Barclay 12 March 2025 124/16-17, 134/25-135/2; INQ000521966_0010-0011, 0022 paras 26, 61
157 Stephen Barclay 12 March 2025 112/17-113/5
158 Stephen Barclay 12 March 2025 115/10-116/2, 137/20-138/4
159 Stephen Barclay 12 March 2025 124/2-8, 135/25-136/1

- In March 2020, Mr Barclay's office emailed Department of Health and Social Care officials to express "*deep discomfort with the apparent lack of due diligence*" undertaken to ensure that a batch of PPE products purchased for $20 million was safe but "*felt that there was no option but to approve the request*", given that the Treasury was "*told that there was only two weeks of stock remaining*".[160]
- In March 2020, Mr Barclay requested a detailed breakdown from the Department of Health and Social Care about demand modelling against the supply curve of equipment and staffing before approving a pre-order of testing kits for £75 million, but was informed by the Department of Health and Social Care that there was insufficient time for such scrutiny.[161]
- In June 2020, as Mr Barclay told the Inquiry, he "*reluctantly*" and "*with significant reservations*" approved a request from the Department of Health and Social Care to enter into a long-term domestic PPE manufacturing contract with a total contract value of £307.6 million, complaining of the failure of data to be shared with the Treasury in a timely manner.[162]

6.94. Mr Young told the Inquiry that, especially at the outset of the pandemic, necessarily fast-paced decision-making was incompatible with the Treasury's requests for information, as they "*distracted people*" from the immediate priority of procuring healthcare equipment.[163]

6.95. Given the priority afforded by the Department of Health and Social Care to respond to the pandemic by procuring healthcare equipment at nearly any cost, the Treasury had little choice but to accede to the Department of Health and Social Care's requests to increase spending.[164] Mr Barclay told the Inquiry that, when under pressure to approve large sums of expenditure in extremely short periods of time and unable to apply proper scrutiny, although "*deeply uncomfortable*", he had no choice but to approve them.[165]

6.96. The situation did not improve as the pandemic progressed. Mr Barclay observed that, in January 2021, he was still concerned with:

> "*the pattern of behaviour of last minute or retrospective requests combined with inadequate transparency on data*".[166]

6.97. The Inquiry recognises that the Department of Health and Social Care was under severe pressure, particularly in the early days of the pandemic. However, as the global market for PPE and other medical equipment began to settle down, the department should have ensured that it shared as much information as it could,

160 INQ000572255; INQ000574180_0005 para 20; INQ000507646
161 INQ000572260; INQ000574180_0005 para 20
162 INQ000528097_0001; INQ000574180_0007 para 20
163 INQ000563070_0020 para 80
164 Stephen Barclay 12 March 2025 104/13-16, 108/4-13; David Williams 27 March 2025 10/7-18; INQ000536345_0012 para 62
165 Stephen Barclay 12 March 2025 107/2-15, 108/7-13
166 INQ000574180_0010; see also INQ000477872_0001-0008; INQ000574002

as soon as possible, with the Treasury. All government spending decisions involve public money, whether in an emergency or not, and should be subject to proper scrutiny – even more so when the sums of money are as huge as they were in the pandemic.

Inconsistent application of spending conditions on personal protective equipment

6.98. The Treasury relied on the judgement of the Department of Health and Social Care's accounting officers to ensure that there was value for money (defined by the Treasury as achieving the best mix of quality and effectiveness for the least outlay) in the procurement of PPE.[167]

6.99. During the pandemic, for the vast majority of offers – which were those under £100 million – there were only two accounting officers: Jon Fundrey (Co-Director of Finance at the Department of Health and Social Care from March to August 2020) and Mr Young. For offers above £100 million, there was one: David Williams (Second Permanent Secretary to the Department of Health and Social Care from March 2020 to April 2021).[168] The accounting officers were required to undertake a series of onerous tasks to scrutinise expenditure on billions of pounds' worth of PPE. This included:

- considering each offer – comprising up to a dozen complicated technical, contractual and financial documents as part of the pack of material sent to them;[169]
- assessing each offer against five sets of complex data analysis, each setting out different aspects of the buying strategy and PPE market;[170]
- applying the four key principles of regularity, propriety, value for money and feasibility/deliverability from the guidance *Managing Public Money*;[171] and
- making a "*rounded*", "*personal*" judgement, with the application of "*common sense*", as to whether to proceed with an offer.[172]

6.100. The accounting officers had to contend with chasing and filling in gaps in a cumbersome to-and-fro exchange of emails with other officials to ensure that there was an audit trail, handling on average 4 – but sometimes up to 11 – offers worth many hundreds of millions of pounds in one day.[173] The volume and complexity of material they were required to assimilate and the speed and pressure under which they had to work meant that ensuring consistency was challenging, to say the least.[174]

167 INQ000521966_0057 paras 2-3; *Managing Public Money*, HM Treasury, October 2007, p24, para 4.2.3 (INQ000092622)
168 INQ000475015_0003-0004 para 10.3; INQ000480114_0001-0002 para 3
169 Chris Young 25 March 2025 17/21-23/25
170 INQ000563070_0012-0013 paras 42a-e; INQ000563145; INQ000339143; INQ000563097; INQ000518325; INQ000563176
171 *Managing Public Money*, HM Treasury, October 2007, p20, box 3.2 (INQ000092622)
172 Chris Young 25 March 2025 23/16-25; David Williams 27 March 2025 7/18-21; INQ000475015_0006 paras 18-19
173 INQ000563070_0006, 0011, 0015 paras 24, 35, 51-52
174 David Williams 27 March 2025 32/5-16

6.101. One of the most important pieces of data that accounting officers were required to consider to ensure value for money was price analysis. This set out the range and average of prices paid over a two-week period in an extremely volatile market for different types of PPE.[175] The aim was to comply with the Treasury condition not to buy PPE at more than 25% of the average price. To rely on price benchmarking, there needed to be an accurate alignment of the data with the types of equipment being purchased. Yet this did not happen because officials were attempting to process far too great a quantity of information.[176]

6.102. As Mr Williams told the Inquiry, the challenge in consistently applying the Treasury's spending conditions was that, while processing and evaluating a large number of offers in a dynamic and fluid market, "*in the end the price that really mattered was what you could actually do a deal for*".[177]

6.103. Accounting officers were prepared to take risks and make judgements based on data that were only "*just about*" adequate.[178] While qualified finance professionals, they were not used to exercising their judgement at the "*frequency and pace*" required during the pandemic and did not have adequate tools – beyond the written *Managing Public Money* guidance – from the Department of Health and Social Care to assist them with analysing the data.[179]

Exceptional spending

Ventilator Challenge

6.104. In the Ventilator Challenge, the Cabinet Office acted as quickly as possible to innovate, design and manufacture ventilators at a time when a serious shortfall across the UK was predicted.[180] As Dan Webster, Deputy Director in the Cabinet Office Complex Transactions Team from 2017, explained:

> "*We did not engage with spend controls in the way that they would typically operate outside of a crisis.*"[181]

Spending in the Ventilator Challenge was less about developing and adhering to budgets and more focused on delivering projects at speed within the broad limits set by the Treasury.[182]

175 INQ000496719; David Williams 27 March 2025 10/1-11/7
176 David Williams 27 March 2025 17/2-31/16
177 David Williams 27 March 2025 29/19-23
178 David Williams 27 March 2025 32/17-33/14
179 Chris Young 25 March 2025 6/17-18, 10/8-22; INQ000563070_0004 para 18; David Williams 27 March 2025 34/2-24
180 INQ000540487_0009, 0018 paras 32, 69; INQ000497031_0064 paras 4.3-4.4
181 INQ000540487_0019-0020 para 74
182 INQ000540487_0019 para 74; INQ000497031_0098-0099 paras 4.137-4.141

6.105. Professor Sanchez-Graells considered that spending controls in the Ventilator Challenge were "*extremely limited*".[183] One of the conditions imposed by the Treasury on the authority delegated to the Cabinet Office to spend more than £400 million was that the Cabinet Office had "*to ensure that as robust a procurement process as possible is being followed in the time allowed*".[184] Professor Sanchez-Graells did not consider that this happened, given the uncertainty about how many ventilators could be procured.[185] There were, however, some spending controls – including embedding Cabinet Office commercial specialists into the ventilator design projects themselves – as well as audit and, where costs were sought to be reimbursed, analysis of project costs by the Ministry of Defence's Cost Assurance and Analysis Service.[186]

6.106. Mr Webster acknowledged that there were inevitably decisions which involved a degree of risk of wasted costs because of the pace of the project and the spending decisions that had to be made.[187] The Treasury also accepted at the time that there were "*very large spending risks*" in making contracts rapidly and attempting new designs, but this was balanced against the importance of getting multiple ventilator production lines running immediately, given the urgent need.[188] According to the Cabinet Office, £143.1 million was written off on rapidly manufactured ventilator designs and parts not retained within the Ventilator Challenge programme or not placed into production.[189] The light-touch oversight of the Ventilator Challenge by the Treasury was, however, an advantage in terms of speed and flexibility when it came to innovating in a crisis.

6.107. Given the increased risk this type of fast-paced emergency innovation could cause to public expenditure in the event of a future pandemic, the Treasury must always ensure that it has proper – even if light-touch – oversight of expenditure on this scale. The blueprints outlined in Chapter 4: Global supply chains and domestic industrial resilience and proper planning for the procurement of innovative critical care equipment and supplies would mitigate this risk.

Testing programme

6.108. The testing programme was initially within the Department of Health and Social Care and did not have its own budget or authority to make spending decisions.[190] As this was a novel and developing field of emergency procurement, there was initially no agreed process. The testing programme's policy targets were not set by NHS Test and Trace but by Mr Hancock and, occasionally, Mr Johnson. As a result, NHS Test and Trace often had to expand procurement to respond to public announcements,

183 INQ000539153_0125 para 314
184 INQ000480114_0003 para 11; INQ000497031_0099 para 4.141
185 INQ000539153_0125 para 314
186 INQ000540487_0020 para 75
187 INQ000540487_0020-0021 para 79
188 INQ000477812; INQ000521966_0029 para 88
189 INQ000573666_0011
190 INQ000521972_0010 paras 3.3-3.4; INQ000562340_0010 para 12f

making procurement and spending decisions at short notice with reduced timescales.[191] Decisions on spending needed input from NHS Test and Trace, the Department of Health and Social Care, the Cabinet Office and the Treasury, but there was no established process between these bodies.[192]

6.109. The testing programme did not have delegated authority to approve spending or its own procurement function until after September 2020.[193] Contracts were signed by Department of Health and Social Care officials, which meant that extra time was spent getting the signatory up to speed with a contract they had had no role in negotiating.[194] The testing programme experienced difficulties in obtaining Treasury approval for spending due to policy disagreements between departments.[195] This resulted in an agreed increase in delegated authority from September 2020, but such disagreements continued to occur. For example, in December 2020, NHS Test and Trace was simultaneously being encouraged to reduce its operations by the Cabinet Office and to increase its operations in response to the new Covid-19 variant by 10 Downing Street.[196]

6.110. Dr Beverley Jandziol (Commercial Specialist in the Complex Transactions Team at the Cabinet Office from September 2019 to May 2022, deployed to the Department of Health and Social Care's Covid-19 National Testing Programme, which became NHS Test and Trace, from March to December 2020) described the experience as "*moving of the goal posts*", with mixed messages from the UK government contributing to a lack of effective scrutiny and control over spending on testing equipment.[197] In one notable example (typical within the testing programme) in July 2020, Lord Agnew and Sir Gareth Rhys Williams raised concerns about a late request for spending approval on the expansion of laboratory capacity, with Lord Agnew asking:

> "*why, when we have known for at least 3 ½ months that testing is a vital plank in dealing with this disease, I was given less than one day to approve £1bill+ transaction*".[198]

191 INQ000562340_0032-0033 para 65
192 INQ000562340_0017-0018 para 24
193 INQ000521972_0010 para 3.4
194 INQ000562340_0010, 0075 paras 12f, 181
195 INQ000562339_0021 para 5.18
196 INQ000562339_0021 para 5.19
197 INQ000562340_0032-0033 para 65
198 INQ000471020_0001

Case study: Expanding laboratory capacity for testing

On 22 July 2020, the Cabinet Office was asked by NHS Test and Trace to approve a business case to spend approximately £1.12 billion over six months to expand laboratory capacity to support UK testing (known as 'Lighthouse Laboratories').[199]

The testing programme had yet to receive approval for a business case based on a target of 500,000 tests per day and, when the target was revised by the Department of Health and Social Care to 800,000, the business case was redrafted.[200] Sir Gareth Rhys Williams queried the request, asking why a direct award (ie the award of a contract without a competitive tendering process) was necessary and observing: "*While I get that the political imperative is to set this up, and fast, there are aspects I'm really not happy about!!!*"[201] The business case was drafted by Dr Jandziol, who explained that the process had been "*protracted and frustrating*", due to "*indecisiveness*" by ministers about the target testing capacity.[202]

On 24 July 2020, Simon Ridley, Director General of the Covid-19 Taskforce from May 2020 to July 2021, observed that the processes between NHS Test and Trace and the Department of Health and Social Care had "*clearly not been right*" and the Cabinet Office and the Treasury had been put in the "*unenviable position of getting something late and being under pressure to move extremely fast*".[203] There were "*complex*" *and* "*confused*" processes, with decisions being made sequentially rather than in parallel, which slowed down approvals.[204]

6.111. This was not an isolated incident for the testing programme. In July 2020, Dido Harding, Baroness Harding of Winscombe (Executive Chair of NHS Test and Trace from May 2020 to May 2021), wrote to Sir Gareth Rhys Williams stating that the two biggest risks to the success of the testing programme were a lack of commercial resources and delays in commercial processes.[205] Baroness Harding told the Inquiry that limits on NHS Test and Trace's delegated authority to approve spending without Treasury approval caused capacity issues in the testing programme in the autumn of 2020.[206]

6.112. Until the appointment of a Chief Commercial Officer of NHS Test and Trace in August 2020, decisions about spending on testing equipment were made and communicated to the Treasury on an ad hoc basis. In August 2020, the testing programme's delegated authority was increased to enable spending up to

199 INQ000477938_0007-0008
200 INQ000563399_0001-0005
201 INQ000477938_0006
202 INQ000562340_0017-0018 para 24
203 INQ000477938_0001-0002
204 INQ000477938_0001-0002
205 INQ000477938_0004
206 INQ000562339_0021 para 5.18

£25 million without needing Treasury approval but, as costs continued to escalate, the problem continued to hamper the testing programme and did not allow for adequate scrutiny by the Treasury.[207] Lord Agnew described his experience of working with the Treasury and the Department of Health and Social Care to agree on funding as "*extremely frustrating*".[208] He said that he was "*never in control*" and more often than not he was presented with a "*fait accompli*" (ie a decision that was close to being taken or had already been taken) for emergency spending that needed to be authorised.[209]

A better approach to managing public money

6.113. In the procurement of PPE and testing equipment, there were inadequate processes put in place by the Department of Health and Social Care, NHS Test and Trace, the Cabinet Office and the Treasury for the proper scrutiny and control of spending. By contrast, in the Ventilator Challenge, as innovation was prioritised and the risk of potential failure was accepted, the processes matched the purpose of the programme.

6.114. Those responsible for spending decisions in an emergency, including in the Treasury, need adequate time and information to scrutinise requests. Systems imposed by the Treasury to control expenditure need to be applied consistently. If novel healthcare equipment is being procured and innovation prioritised, processes must be clear and yet flexible enough to allow for risks to be taken, while ensuring there is robust financial oversight.

Fraud and corruption

6.115. There is a heightened risk of fraud and corruption whenever governments engage in large-scale emergency spending, as money is spent quickly and rules may be relaxed to prioritise responding to the crisis over preventing wrongdoing. As the Government Counter Fraud Function within the Cabinet Office noted in a 20 May 2020 report, it was known that fraud would be happening; the question was "*not whether, but how much*" and how it could be limited.[210]

6.116. The National Crime Agency told the Inquiry:

> "[O]*rganised criminal gangs adapted rapidly in order to exploit opportunities created by the pandemic, such as selling non-existent, fake or substandard PPE equipment.*"[211]

207 INQ000562339_0021 para 5.18; INQ000514384
208 INQ000536345_0013 para 65
209 INQ000536345_0013 para 65; INQ000514384
210 INQ000497031_0206 paras 5.26-5.27; INQ000477927
211 INQ000514300_0005 para 21

In response to the increased risk, in March 2020 the National Crime Agency's National Economic Crime Centre established Operation Etherin to assist the PPE Cell with assessing the risk of fraud in advance of the Department of Health and Social Care entering into contracts with suppliers.[212]

6.117. The Department of Health and Social Care's fraud prevention principally comprised pre-contractual checks by:

- the PPE Cell of due diligence documents, using publicly available and government databases, including a fraud risk-checking tool;[213]
- the Department of Health and Social Care's Anti-Fraud Unit;[214] and
- the National Crime Agency, starting in May 2020, against its fraud intelligence database: of 6,269 companies checked, the National Crime Agency shared with the Department of Health and Social Care information on 40 potential suppliers identified as higher risk.[215]

The Cabinet Office's counter fraud team (known as the Centre of Expertise, which brought together the Cabinet Office Counter Fraud Function with other strands of Cabinet Office commercial expertise) also provided advice to the Department of Health and Social Care on mitigating the risk of fraud.[216]

6.118. There was a trade-off between the pace at which the UK government and devolved administrations had to respond to the pandemic by rapidly procuring healthcare equipment and appropriately mitigating the increased risk of fraud and corruption, which had the potential to slow down the procurement operation.[217]

6.119. The Department of Health and Social Care sought to balance the urgent purchase of healthcare equipment while assuming the risk of losing money to fraud.[218] The competition for PPE and the pace of procurement was such that, generally, due diligence checks had to be completed within 24 to 48 hours and, from April 2020, for promising offers, within 4 hours.[219]

6.120. Early in the pandemic, due to "*workload and resourcing constraints*", full due diligence reports were not completed at the start of the PPE procurement process, with the responsibility generally being shifted to the PPE Cell's closing team to identify and mitigate risk.[220] As Professor Sanchez-Graells explained, not increasing the capacity to conduct thorough due diligence at the start of the procurement process meant that, by the closing stage, there may have been "*significant pressure*"

212 INQ000514300_0005 paras 21-23
213 INQ000528391_0127 paras 470-480
214 INQ000528391_0042-0043, 0141-0145 paras 148-150, 519-535
215 INQ000514300_0007 para 34; INQ000514300_0008 para 42
216 INQ000514029_0005-0006 para 1.9
217 INQ000477927_0001 paras 2.1-2.3
218 INQ000528391_0043 para 151b
219 INQ000497031_0206 paras 5.25-5.26
220 INQ000528391_0129-0130, 0142 paras 477-480, 527

to close contracts with suppliers on the basis that they appeared able to supply the necessary healthcare equipment rather than on the basis of their underlying credibility.[221] This increased the risk of fraud.

6.121. The Department of Health and Social Care's Anti-Fraud Unit was a small team of ten officials, of whom only six were accredited by the Government Counter Fraud Function with investigative expertise.[222] This team did not have a formal role in the procurement process and assessed the risk of fraud only on an ad hoc basis.[223] There was no effective anti-fraud strategy until 1 June 2020, by which time the PPE supply had stabilised (see Chapter 2: Emergency procurement and distribution during the pandemic).[224]

6.122. The Department of Health and Social Care spent a total of £8.6 billion between March and June 2020 in hundreds of contracts with new suppliers, making advance payments as necessary and sometimes entering into contracts "*at risk*" in the pursuit of PPE.[225] Although the procurement and distribution of PPE was correctly prioritised, the Department of Health and Social Care failed to devote the resources to fraud prevention that expenditure on the speed and scale of the Covid-19 pandemic warranted.

6.123. The Cabinet Office's counter fraud team estimated that, with its help, the Department of Health and Social Care prevented £139 million being lost to fraud relating to PPE procurement.[226] According to the Department of Health and Social Care, while £58 million of loss to fraud was prevented by its Anti-Fraud Unit, an estimated £256 million was still lost. As at December 2024, although efforts at recovery were ongoing, the Department of Health and Social Care's Anti-Fraud Unit had only been able to recover approximately £63 million (25%).[227]

6.124. Following the pandemic, the investigation and prosecution of offences in connection with suspected procurement-related fraud has been rare.

6.125. The Crown Prosecution Service told the Inquiry that there was only one investigation, into PPE Medpro Ltd, across all of England and Wales relating to the procurement of PPE during the pandemic (see Chapter 5: Procurement and distribution expertise and experience).[228] The Serious Fraud Office received 195 referrals of suspected fraud relating to the procurement of PPE and test kits but has not pursued any prosecutions.[229] No cases were referred to the Insolvency Service (the lead criminal enforcement agency for insolvency-related fraud and corporate misconduct) or

221 INQ000539153_0109 para 296.2
222 INQ000528391_0042-0043, 0141-0145 paras 148-150, 519-535
223 INQ000528391_0042-0043, 0141-0145 paras 148-150, 519-535
224 INQ000528391_0129-0130, 0142 paras 477-480, 527
225 INQ000528391_0005-006, 0036, 0084 paras 16-17, 127bi, 308
226 INQ000514029_0023 para 3.54
227 INQ000528391_0146 para 537, Table 7
228 INQ000528584_0007 para 30
229 INQ000527569_0009-0011, 0014 paras 52-63, 76

Companies House (the UK's registry for limited companies) for investigation or prosecution relating to the procurement of key healthcare equipment or supplies.[230]

6.126. The Crown Office and Procurator Fiscal Service in Scotland told the Inquiry that it had no "*recollection of any allegations, investigations or criminal reports*" relating to the fraudulent supply of medical equipment or supplies, and Police Scotland confirmed that there were no criminal investigations relating to procurement.[231] The Public Prosecution Service for Northern Ireland told the Inquiry that it had:

> "*no record of any cases involving any offences relating to the procurement of key healthcare equipment and supplies during the pandemic*".[232]

The Metropolitan Police Service confirmed that there was no record of any investigation or prosecution linked to the procurement of key healthcare equipment and supplies.[233]

6.127. In December 2024, Tom Hayhoe was appointed by the Treasury as the UK government's Covid Counter Fraud Commissioner. In his report, published in December 2025, he observed that £325 million worth of legal claims against PPE suppliers were ongoing and that a further £95 million may be recovered.[234] Mr Hayhoe endorsed proposals by the Department of Health and Social Care not to pursue legal claims worth £762 million against some PPE suppliers (in which fraud may be involved) due to the low prospects of success.[235]

6.128. In December 2025, the Home Office published the *UK Anti-Corruption Strategy 2025*. Although the strategy set out a generally positive approach to mitigating the risk of corruption in non-emergency times, it wrongly suggested that the Covid Counter Fraud Commissioner had a wider remit than he had to investigate corruption and recoup public money.[236] The *UK Anti-Corruption Strategy 2025* fails to set out any measures, such as the elimination of high priority lanes or a more robust approach to conflict-of-interest checks, that should be taken to mitigate specifically against the risk of corruption during an emergency.[237] Although the UK government's stated view is that evidence of corruption in public procurement is "*largely*

230 INQ000513151_0002 paras 5-7; INQ000504145_0003-0004 paras 15-17
231 INQ000500356_0014-0015 paras 48-50; INQ000520827_0005-0006 paras 23-24
232 INQ000521971_0003 paras 16-18
233 INQ000520827_0006 paras 26-27
234 *Pursuing Recoveries and Preventing Reoccurrence: Final Report of the Covid Counter Fraud Commissioner*, HM Treasury, December 2025, para 2.10 (https://assets.publishing.service.gov.uk/media/693807357a605b2d61cd8f54/E03505750_HMT_CP_1462_v04_ELAY.pdf; INQ000660083)
235 *Pursuing Recoveries and Preventing Reoccurrence: Final Report of the Covid Counter Fraud Commissioner*, HM Treasury, December 2025, para 2.12 (https://assets.publishing.service.gov.uk/media/693807357a605b2d61cd8f54/E03505750_HMT_CP_1462_v04_ELAY.pdf; INQ000660083)
236 *UK Anti-Corruption Strategy 2025*, Home Office, December 2025, p17, para 33 (https://assets.publishing.service.gov.uk/media/6932caa7375aee4a15ee8c8c/36.37_HO_JACU-Strategy_v12b_FINAL_WEB.pdf; INQ000660082); *Pursuing Recoveries and Preventing Reoccurrence: Final Report of the Covid Counter Fraud Commissioner*, HM Treasury, December 2025, pp14, 21-22, paras 1.13, 2.10-2.12 (https://assets.publishing.service.gov.uk/media/693807357a605b2d61cd8f54/E03505750_HMT_CP_1462_v04_ELAY.pdf; INQ000660083)
237 *UK Anti-Corruption Strategy 2025*, Home Office, December 2025 (https://assets.publishing.service.gov.uk/media/6932caa7375aee4a15ee8c8c/36.37_HO_JACU-Strategy_v12b_FINAL_WEB.pdf; INQ000660082)

anecdotal", there is an increased risk of corruption in an emergency, as advantage may be taken of the government's urgency in responding to the crisis.[238]

6.129. A tailored approach to mitigating the risk of fraud and corruption in an emergency such as a pandemic and enforcement following an emergency is needed. The Inquiry endorses the proposal of the Covid Counter Fraud Commissioner that fraud controls should be embedded and stress-tested as part of pandemic planning and preparedness.[239] In the event of a future pandemic, there should be a well-resourced, systematic approach to identify, detect and prevent fraud and corruption and a strong law enforcement response following the emergency.

Improving public confidence in emergency procurement

6.130. Effective transparency, governance and accountability in emergency procurement are important to ensure that, even in a global pandemic, the public has confidence that public money is being spent appropriately, in accordance with clear rules, and that decision-makers act with integrity.[240] In an acute emergency, there will be trade-offs. Protection of the public in a pandemic must always take priority. The integrity of public spending is nonetheless important.[241] Suspicion, scepticism and cynicism about the motivations of government damage the trust in institutions that is critical to a country's ability to respond effectively.

6.131. Even where circumstances do not permit open competition and direct awards are to be used, the underlying procurement principles should remain the same.[242] In his report on procurement during emergencies, Professor Sanchez-Graells explained that transparency, value for money and accountability will continue to apply, but the "*balance between the principles might shift*", as they are applied in a way that is proportionate to the urgency of the situation.[243]

6.132. Public confidence in the integrity of bodies responsible for emergency procurement during the pandemic was undermined by delays to the publication of contract information, the unfairness of the High Priority Lane and insufficiently robust processes to scrutinise and control spending.[244] The Covid-19 pandemic revealed a system that was unprepared to balance the competing demands of transparency,

238 *UK Anti-Corruption Strategy 2025*, Home Office, December 2025, p17, para 33 (https://assets.publishing.service.gov.uk/media/6932caa7375aee4a15ee8c8c/36.37_HO_JACU-Strategy_v12b_FINAL_WEB.pdf; INQ000660082); INQ000539153_0031 para 91
239 *Pursuing Recoveries and Preventing Reoccurrence: Final Report of the Covid Counter Fraud Commissioner*, HM Treasury, December 2025, p10 (https://assets.publishing.service.gov.uk/media/693807357a605b2d61cd8f54/E03505750_HMT_CP_1462_v04_ELAY.pdf; INQ000660083)
240 Daniel Bruce 4 March 2025 129/15-19; INQ000539153_0025 Summary Box 6
241 Gareth Rhys Williams 4 March 2025 179/12-16
242 Albert Sanchez-Graells 4 March 2025 15/2-5
243 Albert Sanchez-Graells 4 March 2025 13/15-17, 14/19-15/5
244 INQ000527634_0004 para 7

governance and accountability with the emergency procurement and distribution of healthcare equipment.

6.133. The Procurement Act 2023 and The Procurement Regulations 2024, which came into force in February 2025, made the following key changes to the transparency requirements in England, Wales and Northern Ireland:[245]

- New requirements were introduced to publish notices setting out important information about a contract prior to, at the time of, and following its direct award. These are called 'contract details notices' when published prior to an award and 'contract award notices' when published after an award. The Procurement Act 2023 requires both to be published.[246] During the Covid-19 pandemic, it was only necessary to publish such a notice after a contract had been awarded.[247]
- A Procurement Review Unit was established to investigate alleged breaches of the rules, issue recommendations and publish lessons learned.[248]
- Requirements were introduced to use a centralised digital platform and carry out a conflict-of-interest assessment.[249]

6.134. The requirement for a centralised digital platform for the publication of contract information is a promising development, but it will only enhance transparency if there are tools to collate information quickly for publication and to flag deadlines. In Scotland, the regulations have, for many years, required the use of a single digital platform, and yet contract award notices were still published late.[250]

6.135. In light of this, it is not yet clear how, in practical terms, a centralised digital platform alone will remedy the administrative burden that prohibited publication during the pandemic. As is examined in Chapter 7: Data, technology and the future of emergency procurement, to be effective, the platform will need to be integrated with the emergency procurement and distribution system.

6.136. The Inquiry is therefore recommending that those responsible for designing emergency procurement systems in the future must ensure the following:

- Any central digital platform to improve transparency must be automated, reduce the administrative burden on officials and speed up the collation and publication of information.

245 INQ000497031_0233 para 7.3; *Transforming Public Procurement*, Cabinet Office, December 2020 (https://assets.publishing.service.gov.uk/media/5fd77b11e90e076630958ecc/Transforming_public_procurement.pdf; INQ000475569). See also Procurement Act 2023, sections 44, 50, 53, 82-83, 108-110 (https://www.legislation.gov.uk/ukpga/2023/54/contents); The Procurement Regulations 2024, Regulation 5 (https://www.legislation.gov.uk/ukdsi/2024/9780348259728/contents)
246 Procurement Act 2023, sections 44, 50, 53 (https://www.legislation.gov.uk/ukpga/2023/54/contents); INQ000539153_0156 para 387
247 The Public Contracts Regulations 2015, regulation 112(4) (https://www.legislation.gov.uk/uksi/2015/102/regulation/112/2020-12-31)
248 Procurement Act 2023, sections 108-110 (https://www.legislation.gov.uk/ukpga/2023/54/contents); 'Procurement Review Unit', Cabinet Office, 24 February 2025 (https://www.gov.uk/guidance/procurement-review-unit; INQ000549351)
249 Procurement Act 2023, sections 82-83 (https://www.legislation.gov.uk/ukpga/2023/54/contents)
250 Procurement Reform (Scotland) Act 2014, sections 22-23 (https://www.legislation.gov.uk/asp/2014/12/contents)

- The location of a supplier should not have any bearing on whether information should be published.
- There should be no high priority lane.
- Appropriate processes should be agreed between finance and treasury departments and the departments of health in the UK government and devolved administrations.

Recommendation 10: Improved transparency, governance and accountability in an emergency

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should improve transparency, governance and accountability for procurement in an emergency.

As a minimum, these improvements should include the following:

Enhancing transparency

- Any central digital platform used for procurement must allow for the automated collation of contract information and must reduce the administrative burden involved in publishing contract information.
- Contracting authorities across the UK should be required to publish contract award notices (in Scotland) and contract details notices in addition to contract award notices (in England, Wales and Northern Ireland) irrespective of the country in which the supplier is based.

Governance: Fairness in emergency procurement

- There should be no high priority lane.
- All offers to supply healthcare equipment during a pandemic should be assessed according to the application of objective criteria.

Accountability: Approval process for emergency spending on healthcare equipment

- In advance of a pandemic, each health and social care department in each government should agree, with their respective treasuries or finance departments, a process to scrutinise and approve emergency spending on healthcare equipment to ensure that there is a balance between accountability and timely spending decisions.

Chapter 7: Data, technology and the future of emergency procurement

Introduction

7.1. An effective emergency procurement and distribution system must ensure that suitable equipment in adequate quantities reaches health and social care workers, such as doctors, nurses and care assistants, in good time, while limiting waste and providing value for money. Without the systematic collection, collation, analysis and interpretation of data in the procurement and distribution process, decision-making during a pandemic relies on a combination of guesswork, estimates and the taking of unquantified risks.

7.2. A number of the problems examined in this Report arose from the absence of effective information systems to collect and analyse procurement and distribution data and a lack of modern technology to help those responsible for procurement. Thus, they lacked the ability properly:

- to monitor existing healthcare equipment (Chapter 1: The UK's readiness for emergency procurement and distribution);
- to manage inventories, set accurate buying targets, triage offers of supply and track distribution (Chapter 2: Emergency procurement and distribution during the pandemic);
- to share intelligence on non-compliant equipment (Chapter 3: Regulation, inspection and enforcement);
- to manage supply chains (Chapter 4: Global supply chains and domestic industrial resilience);
- to understand workforce skills and capacity (Chapter 5: Procurement and distribution expertise and experience); and
- to publish contract data and monitor spending (Chapter 6: Transparency, governance and accountability).

7.3. This chapter examines the gaps in the systems of data collection and analysis and the availability of technology to assist those involved in the procurement effort during the Covid-19 pandemic.

Data on existing healthcare equipment

Monitoring personal protective equipment in pandemic stockpiles

7.4. The UK government and devolved administrations did not know with adequate precision before the Covid-19 pandemic struck how much healthcare equipment was in the stockpile (see Chapter 1: The UK's readiness for emergency procurement and distribution) and how much of it was still in date. Maintaining a close-to-zero tolerance for expired stock in the pandemic stockpiles will ensure that the

UK government and devolved administrations are better prepared for the next pandemic.

7.5. One of the most effective ways to monitor and ensure that equipment in the pandemic stockpiles is replenished would be the use of a database that keeps an accurate track of stock entering and exiting warehouses. Most importantly, if the database were combined with electronic monitoring, it could automatically flag with responsible bodies when the stockpiles need to be replenished. Establishing this digital system should be an integral part of pandemic preparedness.

Ventilators

7.6. In relation to ventilators, the principal issues at the start of the pandemic were understanding the number of ventilators available to hospitals, determining the required specifications and forecasting the demand for them.[1] As the pandemic emerged, there were no recent data available to the NHS on the number of existing ventilators, their make, model and capabilities, or whether they were functioning.[2] Prior to the pandemic, NHS trusts made individual purchasing decisions and there was no requirement for them to inform NHS England or the Department of Health and Social Care of the number of ventilators they had in use or in stock.[3] Sir Gareth Rhys Williams, UK Government Chief Commercial Officer from March 2016 to July 2024, explained:

> "*Not having an inventory of how many ventilators: what type, age, state of repair, and where, made trying to estimate how many we would need even harder.*"[4]

7.7. In February and March 2020, surveys of healthcare settings across the UK had to be conducted to determine ventilator capacity.[5] The surveys revealed a significant shortfall in the number of available ventilator beds in terms of what would be needed to respond to the pandemic.[6] Conducting surveys took valuable time – critical in the earliest stages of the pandemic. In Scotland, for example, auditing of health board intensive care unit ventilators and equipment had to be undertaken manually and "*it took days to gather the data and intel needed to do this*".[7] As well as the crucial lost time, had the information been available sooner there would have been a cost saving in the procurement of ventilators, given that the price of ventilators was increasing daily in the early stages of the pandemic.[8]

1 INQ000535017_0008 para 23
2 INQ000572261_0021-0022 paras 99-100; INQ000497031_0064 para 4.4
3 INQ000572261_0021-0022 paras 99-100
4 INQ000536362_0036 para 114
5 INQ000572261_0021-0022 para 100; INQ000562457_0086 para 275; INQ000497031_0064 para 4.3
6 Gareth Rhys Williams 5 March 2025 53/1-6
7 INQ000498141_0130-0131 para 329
8 INQ000495258_0014-0015 para 129

7.8. Notwithstanding the relative success of the Ventilator Challenge (see Chapter 4: Global supply chains and domestic industrial resilience), due to a lack of a central database, the UK "*started out on the backfoot*".[9]

Personal protective equipment inventory management and buying targets

7.9. An effective pandemic procurement and distribution system depends on access to reliable, accurate and up-to-date information on the inventories of healthcare equipment held by health and social care bodies and their rates of use. Without it, modelling demand with any degree of precision is impossible.

7.10. At the start of the pandemic, there was no overall picture of the personal protective equipment (PPE) held within the health and social care sectors across the UK.[10] NHS trusts' inventory data were "*fairly basic*" and their systems were unable to exchange inventory information easily with Supply Chain Coordination Ltd (the central procurement body for the NHS supply chain in England) or NHS England.[11] In non-pandemic times, it was not believed necessary to be able to see centrally what was being held or purchased by individual NHS trusts, but this was critical for procurement and distribution in a pandemic.[12]

7.11. Paul Webster, Executive Director of Governance and Legal and Company Secretary of Supply Chain Coordination Ltd, told the Inquiry that there was:

> "*no way of tracking what the individual Trusts actually already had as there was no centralised information on inventory*".[13]

As a consequence, when the Covid-19 pandemic emerged, there were no effective means for the PPE Cell (which was established by the Department of Health and Social Care in March 2020) to centralise PPE procurement and distribution, or to determine how much PPE was held, how much was being used and how much was being bought by NHS trusts in England. With the exception of Northern Ireland, there was no overall picture of the volumes of PPE held by the health and social care sectors during the pandemic across the UK.[14]

7.12. In Scotland, while NHS National Services Scotland had data on national stock levels, it did not have access to inventory data for individual health boards.[15] To rectify

9 INQ000562457_0085-0086 paras 274-275
10 INQ000498322_0007; Emily Lawson 11 March 2025 56/22-25; INQ000535015_0012-0013 paras 36-44
11 Emily Lawson 11 March 2025 56/22-25; Phillip Prosser 26 March 2025 160/21-161/22
12 Phillip Prosser 26 March 2025 160/21-161/22
13 INQ000492085_0026 para 7.39
14 INQ000514103_0014-0015 paras 32-33; INQ000492085_0026 para 7.39; INQ000498322_0007; Emily Lawson 11 March 2025 56/22-25; INQ000474864_0128 para 546; INQ000299126_0003-0004 para 11; INQ000572261_0047 para 199
15 INQ000474864_0128 para 546

this, daily and weekly physical stock counts had to be conducted by hospitals and reported to NHS National Services Scotland.[16]

7.13. In Wales, different NHS organisations monitored their stock of PPE in different ways and did not always report stock levels consistently or accurately. A system called StockWatch was introduced, but it relied on manual inputting as opposed to automatic stock-tracking software.[17] Joint Equipment Stores (a network of stores used to distribute PPE during the pandemic) and health board staff were slow to adopt the system and did not reliably provide weekly reports of PPE stock and usage. The data were so unreliable that NHS Wales Shared Services Partnership distributed PPE on the basis of average issue volumes and not inventory.[18] Deloitte, a professional services company, was instructed to produce modelling and a dashboard (a visual display of data) showing demand for PPE. However, due to the incomplete data, this modelling could only be viewed as a starting point that NHS Wales Shared Services Partnership had to refine based on other data collected over time – superseding the Deloitte dashboard with its own analysis on a Microsoft Excel spreadsheet.[19]

7.14. The central healthcare equipment procurement body in Northern Ireland, the Business Services Organisation's Procurement and Logistics Service, benefited from an electronic materials management system that tracked real-time stock levels in wards and triggered a pull of stock from warehouses when levels of PPE in hospitals fell below a specified level.[20] At the start of the pandemic, it was more informed about PPE levels in hospitals than other central procurement bodies in the UK, but the system was of limited use, as it was based on turnaround times that were unsuitable for the level of urgency required. During the pandemic, the system of hospitals ordering PPE to replenish depleted stocks was replaced by one in which demand was modelled by the Department of Health (Northern Ireland) and PPE distributed accordingly.[21]

7.15. As there were initially no real-time data on stock or usage rates within health and social care settings across the UK, setting accurate buying targets at the start of the pandemic was impossible.[22] The safest option, adopted by Supply Chain Coordination Ltd and the Department of Health and Social Care at the start of the pandemic, was to purchase on the basis that no PPE was held by NHS trusts. The paucity of data meant that, when the PPE Cell was established in March 2020, it had to rely only on models and estimates of demand to procure and distribute PPE. This continued until May 2020.[23] Purchasing and distribution decisions up until this point were based not on real-time inventory and usage data but on assumptions, uncertainties and projections. In the absence of accurate information on the

16 INQ000521969_0069 para 285
17 INQ000536425_0017-0018 para 76
18 INQ000536425_0017-0018 para 76
19 INQ000536425_0055 para 220
20 INQ000514103_0014-0015 para 33
21 Karen Bailey 26 March 2025 6/16-8/5
22 INQ000497031_0152-0153 paras 4.327, 4.332-4.334; INQ000506021
23 INQ000497031_0153, 0197 paras 4.332-4.334, 4.511

volumes of PPE held in transit, warehouses and health and social care settings or coming in from suppliers, it was impossible to predict demand accurately or measure usage rates.[24]

7.16. The assumptions and uncertainties behind the modelled buying targets included: the number of patient interactions, the risks of being supplied with substandard PPE, NHS trusts purchasing equipment, the rate at which the pandemic might spread, the effects of non-pharmaceutical interventions, and the timing and efficacy of any vaccines.[25] Modellers erred on the side of caution and set high buying targets. In a January 2021 presentation titled 'Modelling Covid 19: Estimation errors discussion paper', the Cabinet Office described this as "[p]*rojection guessing*".[26] It was exactly that. While a better quality of modelling might have contributed to better procurement and distribution decisions, it would have been markedly improved if it had had access to real-time inventory data.[27]

7.17. The speed and scale of emergency procurement during the pandemic, combined with the absence of reliable data on demand and usage and the lag between placing orders and accepting delivery, resulted in excess PPE. Due to the considerable uncertainty in the information available to ministers and procurement officials, this was difficult to avoid. Overall, it was better to have too much PPE rather than too little. However, some of the stock would not be used before its shelf life expired (based on estimated usage rates) and there was clearly waste.[28]

7.18. The total expenditure by the UK government and devolved administrations on PPE and by the UK government on ventilators and testing equipment between 1 January 2020 and 28 June 2022 was approximately £42.3 billion.[29] In May 2026, the Treasury estimated that UK government spending resulting from Covid-19 on all measures, including financial support for businesses, would total £385 billion.[30] Total UK government spending was approximately £853 billion in 2018/19.[31]

7.19. The differences in the nature and scale of the procurement and distribution of healthcare equipment across the UK and in how data were collected during the pandemic meant that direct comparisons of data across the four nations of the UK were difficult to draw. However, to illustrate the scale of the waste:

24 INQ000535017_0014-0015 paras 35-37
25 INQ000497031_0152 para 4.327; INQ000528389_0045-0046 para 3.43; INQ000540760_0027-0028 para 65
26 INQ000506021_0002
27 *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876)
28 INQ000528391_0221 para 821; INQ000536421_0007 para 26
29 INQ000528391_0005-0006 para 17; INQ000521972_0031 para 4.50; INQ000513708_0035 para 150; INQ000512475_0005 para 19; INQ000536425_0006 para 25; INQ000514103_0059 para 182; INQ000498835
30 *2026 HM Treasury COVID-19 Cost Tracker Update*, HM Treasury, 28 May 2026, section 1.1 (https://www.gov.uk/government/statistics/hm-treasury-2026-covid-19-cost-tracker-update/2026-hm-treasury-covid-19-cost-tracker-update; INQ000660297)
31 *Statistical Bulletin: Public Spending Statistics*, HM Treasury, November 2019, p7 (https://assets.publishing.service.gov.uk/media/5dd2745ce5274a06dcb61623/PSS_Nov_2019.pdf; INQ000660256)

- In total, the UK government wrote off £9.9 billion of unused PPE.[32] The UK government reported losses of £156.8 million in the financial year 2020/21 in respect of unused materials, parts and machinery for production of healthcare equipment, £143.1 million of which was in respect of unused ventilator designs and parts not retained within the Ventilator Challenge programme.[33] As of April 2023, the UK government had sold, donated or disposed of 9.7% of the total items of PPE procured.[34]
- In Scotland, between 2020 and 2023, approximately £8.35 million of healthcare equipment, including testing kits and PPE, was written off.[35]
- In Wales, between January 2020 and April 2022, approximately £12 million of PPE was written off.[36] In 2025, a further £5.9 million of PPE was found to be excess to requirements.[37]
- In Northern Ireland, between 2022 and 2025, approximately £15.9 million of healthcare equipment was written off by the Business Services Organisation's Procurement and Logistics Service.[38] In 2023, the Comptroller and Auditor General for Northern Ireland found that approximately £43 million of PPE was at risk of expiry before it could be used.[39]

7.20. With better quality data tracking of the actual usage of PPE and better technology for data analysis, modellers would have been able to predict more accurately the types and quantities of PPE that needed to be purchased. Such a system would analyse in real time the usage rates of PPE and provide feedback to adjust buying targets, making them more accurate and reducing waste. Although it was better to have procured too much PPE during the pandemic than too little – it was better not to risk shortages for health and social care workers – it would clearly have been better if supply had been calibrated more closely with demand.

7.21. It was only as the pandemic progressed that inventory management was improved through the introduction of data analysis systems, including the Foundry system for NHS trusts in England.[40] Dominic Cook, Partner in the Major Programmes team at Deloitte, explained that "[l]*egacy technology*" and "*a lack of interoperability*" meant that there was no nationwide overview of stock levels.[41] Louis Mosley, Executive Vice President of Palantir Technologies UK Ltd (which supplied NHS England and the Department of Health and Social Care with Foundry), told the Inquiry that one of the

32 *Department of Health and Social Care: Annual Report and Accounts 2022-23*, Department of Health and Social Care, 25 January 2024, p223 (https://assets.publishing.service.gov.uk/media/65b235e6160765001118f8ad/DHSC-Annual-report-and-accounts-2022-2023-print.pdf; INQ000496744)
33 INQ000573666_0011
34 INQ000528391_0226 para 851
35 INQ000498141_0062 para 197
36 Jonathan Irvine 25 March 2025 136/11-21; INQ000521969_0029-0031 paras 113-114; INQ000536425_0058 para 230
37 INQ000536425_0058 para 230
38 INQ000514103_0070 para 215
39 'Media release: Comptroller and Auditor General's report on financial audit findings 2023 – Central Government', Northern Ireland Audit Office, 20 December 2023, pp1-2 (https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2023-12/NI%20Audit%20Office%20Media%20Release%20-%20C%26AG%27s%20Report%20on%20Financial%20Audit%20Findings%202023.pdf; INQ000662045)
40 INQ000572261_0036 para 153d; INQ000496738
41 INQ000539152_0040 para 131

issues that confronted the UK government on entering the pandemic was that "*many critical processes were still analog or manual*".[42] Mr Mosley told the Inquiry that data were "*fragmented*":

> "[T]*here was no accurate, holistic, granular, or real-time data on the supply of or demand for critical care equipment or supplies. The relevant data was either captured in varied formats across thousands of disparate systems or collected manually.*"[43]

7.22. Mr Webster observed that there would be a benefit to healthcare settings having "*inventory management systems*".[44] The Inquiry agrees.

Triaging and processing offers

7.23. Suppliers offering PPE were generally required to complete online forms setting out basic information about the equipment they could supply.[45] In the early stages, officials in the PPE Cell processed new offers using a single Microsoft Excel spreadsheet which had been populated automatically with data from an online portal.[46] The spreadsheet grew so large that it became unwieldy, containing approximately 1.4 million pieces of information.[47] There were problems in maintaining data integrity and control.[48]

7.24. It was only from April 2020 that the Cabinet Office used Mendix, a single, shared repository of information. It was a "*significant improvement*" on the use of spreadsheets and made it easier to manage and interrogate data, but it was still only a "*simple*" database used to track offers of healthcare equipment.[49] Mendix had "*no link*" to the Department of Health and Social Care's accounting software, its workflow system was "*rudimentary*", and the quality of data still depended on the diligence and resources of individual caseworkers.[50] The Department of Health and Social Care also relied on "*basic*" Microsoft Excel spreadsheets to record and analyse large quantities of information about offers.[51]

7.25. The information requested about offers should have been more detailed and should have been captured and organised in a more structured way, to allow it to be more efficiently interrogated, filtered and analysed.[52] Offers could then be assessed in accordance with different objective criteria, such as price, quantity, speed of delivery and due diligence on the supplier. With appropriate software, there was scope for

42 INQ000536417_0006 para 10b
43 INQ000536417_0006 para 10a
44 Paul Webster 11 March 2025 123/2-6
45 INQ000539153_0095 para 291.4
46 Darren Blackburn 6 March 2025 91/19-24
47 INQ000534813; Darren Blackburn 6 March 2025 91/19-92/24; INQ000536369_0003-0004 para 3.4
48 INQ000497031_0189 para 4.483; Darren Blackburn 6 March 2025 92/19-93/9
49 INQ000497031_0189 paras 4.484-4.486; Darren Blackburn 6 March 2025 93/2-9; Chris Hall 6 March 2025 99/24-100/12
50 INQ000497031_0189 para 4.487
51 INQ000539152_0017, 0040-0041 paras 43, 132
52 INQ000534603_0028; Darren Blackburn 6 March 2025 88/7-89/1; INQ000539153_0094-0095 para 291.3

this process to be automated, allowing a system to advise on which offers should be progressed and which rejected according to selected criteria. For example, if there was an acute shortage of gowns, then price might be a less relevant factor and greater risk over the level of due diligence could be taken. An appropriate system would be able to select offers automatically which meet these criteria for progression. Such a system would have "*significantly reduced the amount of time and resource required to triage and prioritise PPE offers*".[53]

7.26. The Cabinet Office and the Department of Health and Social Care were both limited by the ability of their software platforms to analyse large quantities of data. Due to outdated data-capturing methods, the triaging of offers to supply PPE was unduly time-consuming.[54] Rather than having an intelligent procurement system, the Cabinet Office and Department of Health and Social Care relied on an often cumbersome, labour-intensive process in which officials were overwhelmed by the data they were required to absorb and assess.[55]

7.27. As the scale of the necessary procurement response became clear, Mendix was decommissioned and the manual process of circulating information via emails and spreadsheets was replaced with a structured electronic workflow for the procurement process.[56] The Department of Health and Social Care moved to using advanced Microsoft Excel-based models to analyse and present data and eventually to an externally sourced procurement and contract management platform called Atamis. This significantly improved the procurement response, but only after the peak buying period had passed.[57]

7.28. In the devolved administrations, although there was a much smaller number of offers to triage, similar systems of web portals and assessment and triage by officials were used. In Wales and Northern Ireland, there was a reliance on legacy technology and labour-intensive systems, for example in the form of manually updated trackers, emailing team members to notify them of next steps, manually recording data in logs and spreadsheets, and relying on the manual uploading of documents.[58] In Scotland, in March 2020, the email inboxes of NHS National Services Scotland staff were overwhelmed with suppliers offering PPE; only in mid-April 2020 did an online portal eventually save time in triaging and processing offers.[59]

7.29. The use of legacy technology and a lack of integrated data-gathering and analysis platforms caused problems at almost every stage of the UK government's procurement and distribution process. The system "*could not support*" the PPE Cell

53 INQ000539153_0100 para 291.10
54 INQ000539153_0100 para 291.10
55 INQ000539153_0097-0098 para 291.8
56 INQ000539152_0017 para 43
57 INQ000497031_0189 para 4.488; INQ000477254; INQ000528391_0123-0124 para 454; Darren Blackburn 6 March 2025 93/10-94/18
58 INQ000512450; INQ000514103_0034-0035 paras 89-90
59 INQ000521969_0041-0042 paras 157-160; *The 2020/21 Audit of NHS National Services Scotland: Response to Covid-19 Pandemic*, Auditor General, October 2021, p11, para 30 (https://audit.scot/uploads/docs/report/2021/s22_211012_nhs_national_services.pdf; INQ000198845)

and the Cabinet Office did not have ready an IT system that could handle the volume of users or transactions.[60] As each UK government department had its own IT system and procurement officials, and as external advisers were often working from home, communication and the sharing and exchange of information were difficult.[61] As Chris Hall (a manager in the PPE Buy Cell (a sub-set of the PPE Cell) from April to June 2020) observed to Sir Gareth Rhys Williams in an email in April 2020, "*IT is killing us.*"[62]

7.30. The extent of the problem can be seen in the responses of the Department of Health and Social Care and the Cabinet Office to the Inquiry. To answer our questions, they had to interrogate multiple systems in different departments and, even after multiple attempts to assemble the information, data were poorly organised or even missing.[63] As a consequence, the procurement and distribution data available to procurement officials during the Covid-19 pandemic and subsequently to the Inquiry were both limited and flawed.[64] The UK government did not have the means to analyse effectively the performance of the systems under which billions of pounds had been spent during the pandemic. This was a completely unsatisfactory state of affairs.

7.31. The deployment of modern technology for large numbers of officials to work together efficiently and for data collection and analysis should have been a key component of scaling up procurement and distribution capacity during the pandemic. The UK government and devolved administrations should make a fully digitalised case management system their ambition. Their aim should be "*better visibility*" of offers to help with triaging and prioritisation.[65] This would mean, for example:

- Multiple offers could be assessed and triaged at the same time.
- The same objective criteria for triaging offers could be applied.
- There would be scope for automation.
- The system could respond quickly to changes in supply, demand and price.
- There would be no need for an improvised system of prioritisation, such as the High Priority Lane (see Chapter 6: Transparency, governance and accountability).

Tracking distribution

7.32. In the early days of the pandemic, following the appointment of Clipper Logistics plc to increase distribution capacity in England (see Chapter 2: Emergency procurement and distribution during the pandemic), staff relied on a paper-based system to keep

60 INQ000497031_0188 para 4.481
61 Chris Hall 6 March 2025 98/20-99/20; INQ000562340_0075 para 180
62 INQ000527547
63 Jonathan Marron 5 March 2025 188/19-190/13; INQ000613602; INQ000536369_0013-0014 paras 6.1-6.2; INQ000528391_0123-0124 para 454; INQ000539153_0095-0097, 0100 paras 291.4, 291.7, 291.10-291.11; INQ000534812; INQ000477254
64 INQ000539153_0095-0100 paras 291.5-291.11; INQ000536417_0006-0008 para 10; INQ000534603_0028
65 Darren Blackburn 6 March 2025 93/10-94/18; INQ000521972_0067, 0070-0071, 0073-0076 paras 5.11, 5.27, 5.30, 5.39, 5.44-5.45, 5.50; INQ000562340_0048-0049 para 114

track of orders and deliveries, pending the introduction of an electronic warehouse management system.[66] Clipper Logistics plc received very little information about incoming orders and physically had to open and check the contents of boxes to check that items met specifications.[67] Supply Chain Coordination Ltd had "*no way of tracking*" orders.[68] The PPE Cell did not know when items would arrive.[69] Clipper Logistics plc staff assisting with the distribution of PPE resorted to directly contacting companies and chasing for estimated delivery dates to build a picture. There was "*no sight*" on incoming PPE – it was only with the help of the Army "*literally calling around suppliers to try to figure out the likelihood that something was going to arrive*" that data on incoming stock were estimated.[70]

7.33. Dame Emily Lawson (National Director for Transformation and Corporate Operations at NHS England (and, from April 2018, NHS Improvement) from November 2017 to April 2020) told the Inquiry:

> "[W]*e couldn't see what was coming into the country. We had no data on what would arrive when*."[71]

7.34. The logistics and distribution system was hampered by a lack of good-quality, real-time data about the locations, delivery times, quantities and types of PPE that were being imported and distributed. Even the technology used by Uniserve (the logistics company used by Supply Chain Coordination Ltd) and other warehousing and distribution companies did not provide real-time information on warehoused, incoming and outgoing stock and was difficult to integrate with other systems. Between May and July 2020, Clipper Logistics plc put in place technology that resolved many of these issues, including by providing real-time tracking data.[72] As a result, by June 2020, the visibility of incoming and outgoing stocks had improved, although by then most of the purchasing and importations had ended because it was estimated that the current supply was generally sufficient.[73]

7.35. In social care, such as for adult care homes, Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021) commissioned a tool called the Capacity Tracker to capture key data about the adult social care sector in England.[74] The data collected included confidence in the level of supply of PPE and an estimate of the levels of PPE in a range of social care settings. This assisted in the prioritisation of distribution to social care settings.

66 INQ000533278_0006 para 5.5
67 INQ000533278_0006 para 5.5
68 INQ000572261_0035 para 153b
69 INQ000572261_0035 para 153b
70 Emily Lawson 11 March 2025 60/12-61/8
71 Emily Lawson 11 March 2025 59/9-16
72 INQ000560895_0017 para 49; INQ000572261_0035 para 153b
73 Emily Lawson 11 March 2025 61/11-62/14
74 INQ000535015_0012-0013 paras 37-44

7.36. Similar problems were experienced in Wales and Northern Ireland. There was a plethora of sites used to store and distribute PPE to the care sector, but there was no data capture at these sites. Accordingly, there was no complete oversight of stock being dispatched by NHS Wales Shared Services Partnership to care providers.[75] There were "*critical weaknesses*" in local authority and primary healthcare distribution centres, with few local stock issue or control mechanisms in place.[76]

7.37. In Northern Ireland, where the health and social care sectors are integrated, although the Department of Health (Northern Ireland) accepted that there were issues with access to PPE on the ground due to problems with "*distribution and logistics*", it is not clear whether those specific problems could have been improved by the use of data and technology.[77] As trusts were responsible for distribution to independent health and social care providers, the overall distribution operation was on a much smaller scale than in England, Scotland or Wales.[78]

7.38. There were "*no direct interfaces*" between procurement and distribution data systems – for example, for managing offers or payments and for tracking shipments – so "*manual workarounds*" had to be created.[79] As different systems were deployed to solve different problems at each stage of the procurement and distribution process, and they each evolved quickly and independently over the course of the pandemic, they did not work effectively together.[80]

7.39. What is required for the effective emergency procurement and distribution of healthcare equipment in a pandemic is either a single overarching system or a number of systems that are capable of sharing data with each other in real time and of being interoperable (ie able to work together).[81] As Jonathan Marron (Director General at the Department of Health and Social Care from June 2017 to July 2025) told the Inquiry, to be able to procure and distribute healthcare equipment effectively in a pandemic it is necessary to "*pull together all the data*".[82] This would allow procurement decisions to be calibrated with real-time data on inventories across the health and social care sectors and on equipment held in warehouses and in transit.

Sharing intelligence on non-compliant personal protective equipment

7.40. Those responsible for the inspection of healthcare equipment procured in the pandemic and for the enforcement of regulations designed to protect the safety of end-users did not have access to a single platform through which they could

75 INQ000299126_0003-0004 para 11; INQ000434114_0002 para 9; INQ000470703
76 INQ000500182_0002, 0006 paras 5, 23
77 Chris Matthews 26 March 2025 80/24-81/21
78 INQ000514103_0065 para 202
79 INQ000534603_0027-0028; Darren Blackburn 6 March 2025 89/2-91/18
80 Darren Blackburn 6 March 2025 89/23-91/9
81 Darren Blackburn 6 March 2025 91/14-18
82 Jonathan Marron 5 March 2025 207/21-25

share intelligence about non-compliant PPE entering or being distributed in the UK. Similarly, the health and social care workforce did not have a straightforward means by which they could report non-compliant PPE (see Chapter 3: Regulation, inspection and enforcement). An effective means of gathering and sharing intelligence was not available.

7.41. For there to be an effective system to detect and deter unscrupulous suppliers of PPE and to keep procurement officials informed about the risks of non-compliant PPE entering the market, there should be a digital system that gathers and analyses data on unsafe PPE from those responsible for procurement, inspection and enforcement and from end-users such as doctors, nurses and care assistants. This could then be used to provide real-time feedback on potential high-risk suppliers and assist in enforcement. This would place the safety of end-users at the centre of the procurement system.

Supply chain management

7.42. As a result of procurement officials across the UK having little information about the volume of PPE required by local health bodies and other healthcare providers, PPE was purchased, delivered and "*pushed out*" to the healthcare sector, estimating the sector's requirements and placing orders with multiple distributors and manufacturers to fulfil future forecasted demand.[83] This was one of the principal causes of the 'bullwhip effect', which occurs when a small change in customer demand leads to increasingly large changes at each subsequent stage of the supply chain, creating global market dysfunction (see Chapter 4: Global supply chains and domestic industrial resilience).

7.43. As procurement bodies in the UK had little confidence in any one supplier's ability to fulfil their orders, they placed multiple orders, which made the situation worse. This problem was compounded by other countries' healthcare procurement organisations following the same strategy. Overwhelmed by multiple and inaccurate orders, many contractual relationships broke down, resulting in the creation of a 'spot market' (in which short-term placements of orders are negotiated between buyer and seller at a specific price point, reflecting the market conditions of the specific time). In these circumstances, there is an advantage for buyers that are able to assess and place orders quickly. Spot markets are dominated by buyers with the largest budgets.[84] In the first 100 days of the pandemic, it was a sellers' market, in which prices for healthcare equipment rose rapidly.

83 INQ000474864_0011, 0022 paras 45, 89
84 INQ000474864_0022 para 89

7.44. John Manners-Bell, expert witness on supply chains, told the Inquiry that the best way to mitigate against this kind of supply chain disruption was:

> "*by sharing data throughout the supply chain, whether this is demand, forecast, track and trace or production capacity*".[85]

Supply chain management software that connects demand forecasts to the coordination of supply, organises manufacturing schedules and provides data for metrics for performance analysis will be "*critical*" to improving the visibility of healthcare equipment supply chains in the future.[86] Although in its infancy, supply chain management technology is now capable of automated inventory management, using artificial intelligence to "*track, manage and optimise stock levels without significant human intervention*", resulting in increased efficiency, accuracy and cost-effectiveness.[87] As part of an automated inventory management system, sensors could generate live data about the quantity, status and performance of healthcare equipment. This in turn could inform decisions such as when products should be reordered and in what quantities.[88]

7.45. Boston Consulting Group (a strategy consultancy that provided advice to the Department for International Trade on supply chain resilience during the Covid-19 pandemic) observed that, based on its experience around the world, the public sector typically does not have "*full visibility into its supply chain*" or "*the analytics to identify supply chain risks and bottlenecks*".[89] This was true of healthcare equipment supply chains as the Covid-19 pandemic emerged.[90] Johannes Thoms, Managing Director of Boston Consulting Group, recommended:

> "*a centralised tool or system that allows Government to track and monitor supply chain resilience and identify potential issues that may impact them at as early a stage as possible*".[91]

Boston Consulting Group put together such a tool during the Covid-19 pandemic for the UK government but this had to be updated manually. A more sophisticated model would draw on automated data feeds in real time.[92]

7.46. Dame Emily Lawson told the Inquiry that the UK government should:

> "*ensure that improved oversight of whole supply chains is maintained outside emergency situations, or, at a minimum, that the capacity to rapidly switch on or establish such systems is a codified aspect of an emergency response*".[93]

85 INQ000474864_0022 para 90
86 INQ000474864_0144 para 643
87 INQ000474864_0145-0146 paras 649-651
88 INQ000474864_0145 para 649
89 INQ000474864_0070 para 294
90 INQ000474864_0070 para 296
91 INQ000533610_0013 para 64
92 INQ000533610_0013 para 62
93 INQ000572261_0047 para 199

7.47. Supply Chain Coordination Ltd has started to invest in supply chain management software for warehouse and inventory management.[94] This must be able to cope with a rapid increase in capacity and complexity if it is to be useful in the event of a future pandemic.

Workforce capacity

7.48. As the pandemic emerged, the UK government and devolved administrations had to put together rapidly large teams of officials with a range of skills, expertise and experience from across departments for the emergency procurement and distribution of healthcare equipment (see Chapter 5: Procurement and distribution expertise and experience). The UK government also had recourse to a range of external advisers to support its in-house capabilities. It would clearly assist with planning and preparedness for a future pandemic if the UK government and devolved administrations retained a database of those officials who, having completed the necessary training, could be deployed quickly to scale up the emergency procurement and distribution response.

Publishing contract data and monitoring spending

7.49. One of the reasons for the late publication of 'contract award notices' (setting out key information for the public about contracts) was that, as a result of being stored on different systems, the information was fragmented (see Chapter 6: Transparency, governance and accountability). Collating these data among the "*tsunami*" of paperwork and ensuring that they were accurate was time and labour-intensive. Other tasks, principally procurement and distribution, had to take priority in the allocation of resources.[95]

7.50. When the Government Internal Audit Agency (which provides internal audit services to the UK government) was asked to consider a selection of contracts in August 2020, the data on the Cabinet Office's Mendix system were not detailed enough to establish compliance – "*extensive*" work was required to collate emails and Microsoft Excel spreadsheets to piece together procurement information.[96] NHS National Services Scotland, NHS Wales Shared Services Partnership and the Business Services Organisation's Procurement and Logistics Service in Northern Ireland gave similar reasons for the delays in publishing contract award notices (see Chapter 6: Transparency, governance and accountability).

7.51. The Procurement Regulations 2024 require notices, information and documents relevant to procurement to be published on a centralised digital platform.[97] The digital platform, Find a Tender, was in use prior to the pandemic but has since been

94 INQ000474864_0145 para 647
95 INQ000536362_0034-0035 para 108
96 INQ000497031_0023 para 1.73
97 The Procurement Regulations 2024, regulations 5-6, 15-41 (https://www.legislation.gov.uk/uksi/2024/692/contents/made)

enhanced. All public procurement in the UK must now be carried out using this platform, with only some limited exceptions for the devolved administrations.[98]

7.52. This move to mandatory searchable databases of published contract information provides an opportunity for fast public reporting, the automated collation of data on contract values and spend, and compliance with procurement rules. If used consistently by all contracting authorities, a single, central digital platform could minimise the risk of lost or incomplete data – enhancing transparency and accountability. The effectiveness of these changes will be highly dependent on the performance of the software chosen to act as the central digital platform. As a minimum, the platform should be intuitive and capable of being used by officials with little training, so that information can be collated and published simply and made accessible to the public as quickly as possible.[99] It should form an integral part of procurement systems across the UK.

Developments in emergency procurement and distribution

7.53. At the request of Boris Johnson MP (Prime Minister from July 2019 to September 2022) and the Cabinet Office, Nigel Boardman (later Sir Nigel Boardman) conducted reviews and produced two reports on procurement and distribution during the Covid-19 pandemic.[100] The second – and, for the purposes of the Inquiry, the most important – report was published on 7 May 2021 and made 28 recommendations, all of which were accepted by the UK government.[101] One of his key observations was that there was:

> "*a lack of cloud-based digital systems to support good procurement and logistics … It would be helpful if the Government had access to a common system to support procurement in a crisis*."[102]

98 'Central Digital Platform – factsheet', Government Commercial Function, 11 April 2025, as updated (https://www.gov.uk/government/publications/procurement-act-2023-short-guides/central-digital-platform-factsheet-html; INQ000662043); *Procurement Reform in Wales,* Welsh Government, 19 August 2024 (https://www.gov.wales/sites/default/files/pdf-versions/2024/8/3/1724859989/procurement-reform-wales.pdf; INQ000662046); 'Welsh Procurement Policy Note WPPN 01/24: Transparency – publication of contract award notices', Welsh Government, 3 July 2024 (https://www.gov.wales/sites/default/files/pdf-versions/2024/7/3/1721220420/wppn-01-24-transparency-publication-of-contract-award-notices.pdf; INQ000662047); The Procurement (Wales) Regulations 2024, regulation 5 (https://www.legislation.gov.uk/wsi/2024/782/contents/made)

99 INQ000527634_0159-0161 paras 390-396

100 *Boardman Report on Cabinet Office Communications Procurement*, Nigel Boardman, 8 December 2020, pp12-15 (https://assets.publishing.service.gov.uk/media/608a6e0ce90e076ab07a6d92/Boardman-Review-of-Cabinet-Office-COVID-19-Communications-Procurement-final-report.pdf; INQ000055888); *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876); INQ000569124_0040 para 132

101 *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876)

102 *Boardman Review of Government Procurement in the COVID-19 Pandemic*, Nigel Boardman, 7 May 2021, p21 (https://assets.publishing.service.gov.uk/media/60896ff0e90e076ab07a6d83/Boardman_Review_of_Government_COVID-19_Procurement_final_report.pdf; INQ000055876)

7.54. Inventory management systems for PPE are being introduced in England, Scotland and Wales.[103] In Scotland, health boards are now using a medical equipment management system for intensive care unit equipment such as ventilators.[104] In Northern Ireland, the Business Services Organisation's Procurement and Logistics Service continues to use its "*well-established*" inventory and warehouse management systems, which provide real-time inventory data to those responsible for procurement.[105]

7.55. A number of ministers and officials, including Matt Hancock MP (Secretary of State for Health and Social Care from July 2018 to June 2021), James Bethell, Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021) and Dame Emily Lawson, observed that the UK government and devolved administrations could have harnessed the capabilities of data and technology for the procurement and distribution of healthcare equipment more effectively during the pandemic.[106]

7.56. External advisers suggested that the UK government and devolved administrations should take advantage of recent developments in technology. Mr Mosley recommended that the UK government adopt a "*Common Operating System*" for emergency procurement and distribution, which would:

> "*sit on top of, and be able to integrate with, the multitude of source systems across the local and central government, healthcare and other bodies of national strategic importance*".[107]

7.57. Marc Warner, Chief Executive Officer of Faculty Science Ltd (an artificial intelligence company that provided data analysis expertise to the UK government), recommended that "*the technology for procurement during a national emergency should be ideally the same technology ordinarily in use*", which in normal times is optimised for cost-efficiency and in an emergency for speed.[108] Mr Cook told the Inquiry:

> "[M]*odern technology platforms at a national and local level would enable real-time insights on stock levels and local demand patterns to enable improved supply chain forecasting. This would facilitate a more effective and efficient supply chain during* [business as usual]*, the ability to identify early changes in demand patterns, scale up or down demand capacity, and give the ability to digitally deploy demand management.*"[109]

103 INQ000528585_0087 para 396; INQ000498141_0049, 0182, 0194 paras 148-149, 450, 490; INQ000521969_0068 para 284
104 INQ000498141_0130-0131, 0193 paras 329, 489
105 INQ000514103_0068-0069 paras 209-213
106 INQ000535017_0014 paras 35-37; Emily Lawson 11 March 2025 43/10-47/24; INQ000474864_0020 para 90; James Bethell 19 March 2025 75/20-25; Matt Hancock 19 March 2025 149/9-18
107 INQ000536417_0021 para 50
108 INQ000475067_0006-0007 para 30
109 INQ000539152_0042 para 135

7.58. There is clearly an opportunity for the UK government and devolved administrations, while improving their day-to-day procurement systems, to consider how they could adapt to the speed and scale required to respond effectively to a pandemic. As these were shared problems, the UK government and devolved administrations should cooperate and coordinate on preparing for the emergency procurement and distribution of healthcare equipment during a pandemic.[110] There needs to be investment across the UK in modern technology for the procurement and distribution of healthcare equipment to ensure that, at a minimum, the systems are digitalised, are able easily to share information and are interoperable. Given the importance and cost of emergency procurement to the public during the pandemic, such an investment in data and technology infrastructure to improve decision-making, increase efficiency and reduce waste would clearly be worthwhile.

7.59. There is a general commitment in the Department of Health and Social Care's *Pandemic Preparedness Strategy* (March 2026) to ensure that decision-making will be informed by data analysis. This should apply equally to the emergency procurement and distribution of key healthcare equipment.[111]

Placing data and technology at the centre of emergency procurement and distribution

7.60. The emergency procurement and distribution of healthcare equipment across the UK was hampered by a lack of access by ministers and officials to the kinds of digital solutions and data analysis systems that could have helped them make better, more informed decisions. The approach to emergency procurement and distribution across the UK should be underpinned by placing technology and data at the centre of emergency procurement and distribution systems, with a key feature being the sharing of data and interoperability. The aim should be:

- clearer supply chain visibility;
- better emergency procurement decisions;
- real-time distribution tracking; and
- automated collation of contract data for publication.

7.61. The Inquiry's recommendation sets an ambitious target for the creation of interoperable, digitalised systems for the procurement and distribution of healthcare equipment. While the Inquiry's examination in Module 5 has focused on PPE, ventilators and testing equipment, there is no reason why this could not be applied to other healthcare equipment needed for an emergency. If the UK government and devolved administrations had access to such systems, they would be better

110 INQ000474864_0129, 0131-0132 paras 558, 574
111 *Pandemic Preparedness Strategy: Building Our Capabilities*, Department of Health and Social Care, 25 March 2026, p10 (https://assets.publishing.service.gov.uk/media/69c3c48b93cc6e8b87a6f614/dhsc-pandemic-preparedness-strategy.pdf; INQ000660230)

prepared in a future pandemic to ensure that key healthcare equipment and supplies were provided to health and social care workers and that public money was spent effectively – with better value for money, less waste and greater efficiency.

Recommendation 11: Placing data and technology at the centre of emergency procurement and distribution of healthcare equipment

Within three years of the publication of this Report, the systems for the procurement and distribution of healthcare equipment should be digitalised and interoperable across the UK government and devolved administrations.

As a minimum, these systems should be able to use technology to collect, share and analyse data across the UK in real time on:

- pandemic stockpiles, health and social care sector inventories and usage rates;
- offers of supply, enabling automated comparison, triaging and processing;
- non-compliant healthcare equipment entering the market;
- supply chains, including international delivery times and domestic logistics and distribution data;
- procurement and distribution workforce capacity; and
- spending – automatically identifying, collecting and collating key contract data for publication.

7.62. This Report lays bare the flaws in our current systems for the procurement and distribution of vital healthcare and medical equipment in an emergency. The UK deserves better systems that can properly meet the demands of the next pandemic and avoid waste. They should be better equipped to get the right quantity of supplies, of the right quality, to the right places and at a reasonable cost. The process should be sufficiently transparent for the public to have complete confidence in the integrity of the emergency procurement and distribution system. This can only be achieved with planning and investment.

Appendix 1: The background to this module and the Inquiry's methodology

Background

A1.1. The Right Honourable Boris Johnson MP, Prime Minister from July 2019 to September 2022, formally established the UK Covid-19 Inquiry in June 2022 to examine the preparations for and response to the Covid-19 pandemic in the UK and to learn lessons for the future. In December 2021, he appointed The Right Honourable the Baroness Hallett DBE, a retired judge of the Court of Appeal, as its Chair.

A1.2. On 28 June 2022, the Prime Minister issued the final Terms of Reference for the Inquiry, establishing it under the Inquiries Act 2005.[1] The Inquiry formally opened on 21 July 2022 to:

> "*examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the Inquiry's formal setting-up date, 28 June 2022*".[2]

A1.3. To ensure a full and focused examination of the wide range of issues covered in the Terms of Reference and to produce regular reports, the Inquiry's investigation has been divided into sections or 'modules'. Each module gathers evidence, designates Core Participants and has both preliminary hearings (at which decisions about the procedure for the conduct of its investigations and public hearings are made) and full public hearings where evidence is heard. Details of public hearings are published by the Inquiry.[3]

A1.4. The Inquiry's Module 1, which considered the UK's resilience and preparedness, published its Report in July 2024.[4] The Inquiry's combined Report relating to Modules 2 (UK), 2A (Scotland), 2B (Wales) and 2C (Northern Ireland) – which addressed the UK's core political and administrative decision-making – was published in November 2025.[5] The Module 3 Report relating to the impact of the Covid-19 pandemic on healthcare systems of the UK was published in March 2026.[6] In April 2026, the Inquiry published its Module 4 Report concerning vaccines and

1 See 'Covid-19 Inquiry Terms of Reference', UK Covid-19 Inquiry, 20 July 2022 (https://covid19.public-inquiry.uk/documents/terms-of-reference), which includes translations of the Inquiry's Terms of Reference; for the Inquiries Act 2005, see https://www.legislation.gov.uk/ukpga/2005/12/contents. A separate inquiry is taking place in Scotland, which will evaluate areas where policy was devolved to the Scottish Government, as set out in its Terms of Reference. The UK Covid-19 Inquiry works with the Scottish Covid-19 Inquiry to avoid duplication of work where possible.

2 'Covid-19 Inquiry Terms of Reference', UK Covid-19 Inquiry, 20 July 2022 (https://covid19.public-inquiry.uk/documents/terms-of-reference)

3 For further information, see 'Structure of the Inquiry', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/structure-of-the-inquiry)

4 *Module 1: The resilience and preparedness of the United Kingdom*, UK Covid-19 Inquiry, July 2024 (https://covid19.public-inquiry.uk/documents/module-1-full-report)

5 *Modules 2, 2A, 2B, 2C: Core decision-making and political governance*, UK Covid-19 Inquiry, November 2025 (https://covid19.public-inquiry.uk/documents/module-2-full-report)

6 *Module 3: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom*, UK Covid-19 Inquiry, March 2026 (https://covid19.public-inquiry.uk/documents/module-3-full-report)

therapeutics.[7] This Module 5 Report relates to the procurement and distribution of key healthcare-related equipment and supplies.

A1.5. The Inquiry's currently active modules are as follows:

- Module 6: Care sector[8]
- Module 7: Test, trace and isolate[9]
- Module 8: Children and young people[10]
- Module 9: Economic response[11]
- Module 10: Impact on society[12]

A1.6. A public inquiry is established to examine the facts and to find out exactly what happened. It is an inquisitorial, not an adversarial, process. This Report's conclusions and recommendations are based on an objective assessment of the totality of the evidence received by the Inquiry.

Module 5

A1.7. This Report concerns the procurement and distribution of key healthcare-related equipment and supplies – focusing on personal protective equipment (PPE), ventilators and testing equipment – in England, Wales, Scotland and Northern Ireland.

Outline of Scope

A1.8. As set out in its Outline of Scope, Module 5 focused primarily on the effectiveness of procurement and distribution systems in the period leading up to and during the pandemic.[13] In particular, the matters examined encompassed:

- preparedness and readiness, including pre-existing stockpiles, inventory management and the suitability of PPE for the health and social care sectors;

7 *Module 4: Vaccines and therapeutics*, UK Covid-19 Inquiry, April 2026 (https://covid19.public-inquiry.uk/documents/module-4-full-report)
8 'Care sector (Module 6)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/care-sector-module-6)
9 'Test, trace and isolate (Module 7)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/test-trace-and-isolate-module-7)
10 'Children and young people (Module 8)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/children-and-young-people-module-8)
11 'Economic response (Module 9)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/economic-response-module-9)
12 'Impact on society (Module 10)', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/modules/impact-on-society-module-10)
13 'Module 5: Provisional Outline of Scope', UK Covid-19 Inquiry, 24 October 2023 (https://covid19.public-inquiry.uk/documents/module-5-provisional-outline-of-scope)

- the processes and procedures for procurement and distribution prior to and during the pandemic, including the effectiveness of mutual aid arrangements across the UK;
- the operation of the regulatory regimes for healthcare equipment;
- the UK's capacity to manufacture healthcare equipment and the suitability and resilience of supply chains; and
- openness and fairness in procurement, including publication of contractual information, the management of conflicts of interest, the operation of the High Priority Lane and the application of spending controls.

A1.9. Module 5 prepared a list of issues to supplement the Provisional Outline of Scope, intended as a non-prescriptive guide to provide greater detail about the matters that might warrant investigation.[14]

Core Participants

A1.10. In accordance with rule 5 of the Inquiry Rules 2006 and the Inquiry's Core Participant Protocol, the Chair designates a number of Core Participants – individuals, organisations or institutions with a specific interest – in each module.[15] Core Participants have enhanced rights in the Inquiry process, including receiving disclosure of documents, being represented, making legal submissions and suggesting lines of enquiry. They are also able to apply to the Inquiry for funding to cover legal and other costs.

A1.11. In Module 5, the Inquiry received 37 applications for Core Participant status and the Chair designated 24 Core Participants.

Table 2: Module 5 Core Participants

Name of organisation/individual	Date of designation
Covid-19 Bereaved Families for Justice	11 December 2023
Department of Health (Northern Ireland)	11 December 2023
Federation of Ethnic Minority Healthcare Organisations	11 December 2023
Arlene Foster MLA, The Rt Hon the Baroness Foster of Aghadrumsee DBE and Paul Givan MLA	11 December 2023
Local Government Association and Welsh Local Government Association	11 December 2023
Conor Murphy MLA	11 December 2023

14 'Module 5: List of Issues', UK Covid-19 Inquiry, 3 February 2025 (https://covid19.public-inquiry.uk/documents/module-5-list-of-issues-dated-03-02-2025)
15 The Inquiry Rules 2006, rule 5 (https://www.legislation.gov.uk/uksi/2006/1838/contents/made); 'Core Participant Protocol', UK Covid-19 Inquiry, 21 July 2022 (https://covid19.public-inquiry.uk/documents/uk-covid-19-inquiry-core-participant-protocol)

Name of organisation/individual	Date of designation
Northern Ireland Covid-19 Bereaved Families for Justice	11 December 2023
Michelle O'Neill MLA	11 December 2023
Scottish Covid Bereaved	11 December 2023
Scottish Ministers	11 December 2023
Secretary of State for Business and Trade	11 December 2023
Secretary of State for Foreign, Commonwealth and Development Affairs	11 December 2023
UK Health Security Agency	11 December 2023
Welsh Government	11 December 2023
Chancellor of the Duchy of Lancaster	12 December 2023
Covid-19 Bereaved Families for Justice Cymru	12 December 2023
Department of Health and Social Care	12 December 2023
HM Treasury	12 December 2023
NHS England	12 December 2023
NHS National Services Scotland (known from 1 April 2026 as Public Services Delivery Scotland)	12 December 2023
NHS Wales Shared Services Partnership	12 December 2023
Scottish Health Boards (Scottish territorial and special health boards)	12 December 2023
UK Anti-Corruption Coalition	13 December 2023
British Medical Association	14 August 2024

Public access to Inquiry proceedings

A1.12. In keeping with its public nature and the Chair's commitment to conduct the Inquiry in as open and transparent a manner as possible, arrangements were made for the majority of the Module 5 hearings to be accessible to all who wished to follow them. These hearings were broadcast via livestream on the Inquiry's website or its YouTube channel (where they remain accessible) and members of the public were able to watch the hearings in person.[16]

A1.13. On 24 January 2025, the Chair granted a restriction order (pursuant to section 19 of the Inquiries Act 2005) on the application of the National Crime Agency to prevent a risk of prejudice to possible criminal proceedings that would arise if

16 'Procurement (Module 5) – Public Hearings', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/hearings/procurement-module-5-public-hearings; https://www.youtube.com/@UKCovid-19Inquiry/videos)

the Inquiry considered evidence in public.[17] As a result, a 'closed' hearing took place on 20 March 2025. There are restrictions in place over the disclosure and publication of evidence covered by the restriction order, including the transcript of the closed hearing. The restriction order continues until the conclusion of any criminal proceedings (including prosecution, review and appeals) in relation to PPE Medpro Ltd or unless the order is varied or revoked pursuant to section 20 of the Inquiries Act 2005. When the restriction order is no longer in force, Chapter 5A of this Report will be published, along with any related evidence.

Evidence gathering

A1.14. In Module 5, the Inquiry issued 227 requests for evidence, pursuant to rule 9 of the Inquiry Rules 2006, to organisations and individuals. It received and considered 263 witness statements. In addition, in Module 5 the Inquiry received and reviewed approximately 59,000 documents, comprising exhibits to statements and documents forming part of general disclosure. These amounted to more than 355,000 pages, of which more than 170,000 were disclosed to Core Participants.

A1.15. In Module 5, the Inquiry sent a further 37 requests (in addition to the 227 referred to above) to individuals listed by the Department of Health and Social Care as having made referrals to the High Priority Lane. The Inquiry received 35 witness statements in response, which were disclosed to Core Participants.[18]

A1.16. The Inquiry also received evidence from the Department of Health and Social Care which outlined the purpose and performance of 374 contracts for the procurement of PPE supplies.[19] The data categorised contracts by whether they were handled by the High Priority Lane or an alternative workstream. The data also included more detailed information on the characteristics of the contract – for example, whether contracts were directly awarded to the manufacturer, the types of PPE involved and whether performance issues were encountered. Complete data were unavailable for all contracts.

Every Story Matters

A1.17. As set out in the Terms of Reference, the Inquiry regards it as critical to its work to listen to and consider carefully the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. The Inquiry has done this in a number of different ways, including through its listening exercise, Every Story

17 'Final Notice of Determination: Restriction Order Application in relation to the applications by the NCA dated 9 and 17 December 2024', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/final-notice-of-determination-issued-by-the-chair-of-the-uk-covid-19-inquiry-regarding-the-ncas-application-for-a-restriction-order-dated-24-01-2025); 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/restriction-order-issued-by-the-chair-of-the-uk-covid-19-inquiry-dated-24-01-2025)
18 INQ000660263
19 INQ000660160

Matters, the largest public engagement exercise by a UK public inquiry. It heard from thousands of people about their experiences of the pandemic.[20]

A1.18. Stories were shared with the Inquiry through a webform (including accessible versions), a series of events across the UK and interviews with under-represented groups.[21] Those aged 18 or older were invited to share as much or as little of their pandemic experience as they felt able, without the formality of giving evidence or attending a public hearing. More than 58,000 stories were shared with the Inquiry. The sharing of these experiences has helped the Inquiry to understand events and their impact and has aided the development of recommendations that could reduce suffering in the future. Experiences shared with the Inquiry were analysed and reports – called records – have been produced highlighting the themes that emerge, and telling people's stories in their own words. Every Story Matters records have been used in evidence in relevant modules of the Inquiry.[22]

Disclosure to Core Participants and publication of materials

A1.19. The Inquiry's approach to documents is set out in its Protocol on Documents, which explains key principles for the delivery of documents to the Inquiry, including requests for documents or witness statements pursuant to rule 9 of the Inquiry Rules 2006.[23] This should be read with the Inquiry's Protocol on the Redaction of Documents, which details the approach to the redaction of documents for the purposes of both disclosure to Core Participants and publication.[24]

A1.20. The Inquiry discloses all witness statements and documents it considers relevant to Core Participants in full, subject to any redactions applied in accordance with the Inquiry's Protocol on the Redaction of Documents.[25] To comply with section 18 of the Inquiries Act 2005, the Chair is taking reasonable steps to ensure that members of the public are able to view documents provided to the Inquiry.[26] All documents shown on screen during the course of the hearings appear in the YouTube recording of the evidence and are published on the Inquiry's website at the end of each day. The witness statements of those who give evidence each day are also published in full. Since the conclusion of the hearings, the Chair has granted permission for the publication of further materials, including those referenced within this Report, where she has been satisfied it is necessary to do so.[27]

A1.21. In the event of an objection to the disclosure or publication of relevant material, an application must be made to the Chair for a restriction order in accordance with

20 'Every Story Matters', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/every-story-matters)
21 'Every Story Matters', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/every-story-matters)
22 The Inquiry's Every Story Matters records can be found at: https://covid19.public-inquiry.uk/every-story-matters/records
23 'Protocol on Documents', UK Covid-19 Inquiry, 29 July 2022 (https://covid19.public-inquiry.uk/documents/protocol-on-documents)
24 'Inquiry Protocol on the Redaction of Documents', UK Covid-19 Inquiry, 18 October 2022 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-the-redaction-of-documents)
25 'Inquiry Protocol on the Redaction of Documents', UK Covid-19 Inquiry, 18 October 2022 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-the-redaction-of-documents)
26 Inquiries Act 2005, section 18 (https://www.legislation.gov.uk/ukpga/2005/12/contents)
27 'Documents', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry.uk/documents)

section 19 of the Inquiries Act 2005, following the Inquiry's Protocol on Applications for Restriction Orders.[28] In Module 5, on the application of the National Crime Agency, the Chair issued a restriction order dated 24 January 2025 concerning the publication of irrelevant and sensitive material to prevent a risk of prejudice to possible criminal proceedings that would arise if the Inquiry considered evidence in public.[29] The Chair also issued a restriction order dated 17 March 2025 concerning the publication of irrelevant and sensitive material and a general restriction order dated 13 March 2026 concerning the publication of redacted material.[30]

The instruction of expert witnesses

A1.22. To assist the Inquiry, two experts were appointed to cover topics relevant to Module 5.

Table 3: Expert witnesses

Topic	Expert(s) appointed	Expert report
Public procurement during emergencies	Professor Albert Sanchez-Graells (Professor of Economic Law at the University of Bristol)	INQ000539153
Procurement and distribution of key equipment and supplies	John Manners-Bell (former Honorary Visiting Professor at the London Metropolitan University's Guildhall Faculty of Business and Law)	INQ000474864

Witnesses at public hearings

A1.23. Witnesses are invited by the Inquiry to provide a statement if they have evidence relevant to a particular module. They give evidence under oath or affirmation and are questioned by Counsel to the Inquiry. Counsel for Core Participants can also ask questions with the Chair's permission, pursuant to rule 10 of the Inquiry Rules 2006.[31]

A1.24. At its public hearings in Module 5 between 3 and 27 March 2025, the Inquiry heard evidence from 48 witnesses, including procurement specialists, government ministers and officials, supply chain officials and experts.

28 Inquiries Act 2005, section 19 (https://www.legislation.gov.uk/ukpga/2005/12/contents); 'Inquiry Protocol on Applications for Restriction Orders', UK Covid-19 Inquiry, 18 October 2022 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-applications-for-restriction-orders)
29 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 24 January 2025 (https://covid19.public-inquiry.uk/documents/restriction-order-issued-by-the-chair-of-the-uk-covid-19-inquiry-dated-24-01-2025)
30 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 17 March 2025 (https://covid19.public-inquiry.uk/documents/restriction-order-issued-by-the-chair-of-the-uk-covid-19-inquiry-dated-17-03-2025); 'Restriction Order: Restriction on the publication of material pursuant to section 19 of the Inquiries Act 2005', UK Covid-19 Inquiry, 13 March 2026 (https://covid19.public-inquiry.uk/documents/module-5-general-restriction-order-dated-13-03-2026)
31 The Inquiry Rules 2006, rule 10 (https://www.legislation.gov.uk/uksi/2006/1838/contents/made)

Table 4: Module 5 witnesses from whom the Inquiry heard evidence

Witness (organisation)	Date of evidence
Professor Albert Sanchez-Graells (Professor of Economic Law at the University of Bristol)	4 March 2025
Daniel Bruce (Chief Executive of Transparency International UK, on behalf of the UK Anti-Corruption Coalition)	4 March 2025
Sir Gareth Rhys Williams (UK Government Chief Commercial Officer from March 2016 to July 2024)	4 March 2025; 5 March 2025
Jonathan Marron (Director General at the Department of Health and Social Care from June 2017 to July 2025)	5 March 2025
Max Cairnduff (Commercial Specialist within the Cabinet Office Complex Transactions Team from July 2018 to July 2023, High Priority Lane and Donations Lead in the PPE Buy Cell (a sub-set of the PPE Cell) from April to May 2020 and Director within the Complex Transactions Team from August 2020 to July 2023)	6 March 2025
Darren Blackburn (Deputy Director in the Government Commercial Function Complex Transactions Team at the Cabinet Office from September 2019 to May 2022, Head of New Supplier Sourcing in the PPE Cell from April to July 2020)	6 March 2025
Chris Hall (Deputy Government Chief Commercial Officer from 2016 to July 2020, Deputy Director within the Cabinet Office Complex Transactions Team and a manager in the PPE Buy Cell (a sub-set of the PPE Cell) from April to June 2020)	6 March 2025
Andy Wood (Deputy Director, Commercial Specialist in the Cabinet Office and Lead for the PPE Buy Cell (a sub-set of the PPE Cell) from March to July 2020)	6 March 2025
John Manners-Bell (former Honorary Visiting Professor at the London Metropolitan University's Guildhall Faculty of Business and Law)	10 March 2025
Andrew Mitchell (Director General at the Department for International Trade from May 2020 to November 2023)	10 March 2025
Simon Manley, later Sir Simon Manley KCMG (Director General, Covid-19 at the Foreign and Commonwealth Office from March to September 2020)	10 March 2025
The Rt Hon Michael Gove MP, later Lord Gove (Chancellor of the Duchy of Lancaster from July 2019 to September 2021 and Minister for the Cabinet Office from February 2020 to September 2021)	10 March 2025
Dame Emily Lawson DBE (National Director for Transformation and Corporate Operations at NHS England (and, from April 2018, NHS Improvement) from November 2017 to April 2020, Chief Operating Officer (Interim) at NHS England from November 2023 to March 2025)	11 March 2025
Paul Webster (Executive Director of Governance and Legal and Company Secretary of Supply Chain Coordination Ltd)	11 March 2025

Witness (organisation)	Date of evidence
Julian Kelly (Chief Financial Officer of NHS England from April 2019 (and Deputy Chief Executive from July 2021) until March 2025)	11 March 2025
Alan Brace (Director of Finance of the Health and Social Services Group in the Welsh Government from September 2016 to October 2020)	11 March 2025
Tim Jarvis (Director of Consumer and Competition Policy at the Department for Business, Energy and Industrial Strategy from January 2018 to April 2020, Director of PPE Make from April 2020 to September 2020)	12 March 2025
Graham Russell (Director within the Competition, Markets and Regulatory Reform division at the Department for Business, Energy and Industrial Strategy as Chief Executive of the Office for Product Safety and Standards from 2018)	12 March 2025
The Rt Hon Stephen Barclay MP (Chief Secretary to the Treasury from February 2020 to September 2021 and Chancellor of the Duchy of Lancaster September 2021 to July 2022)	12 March 2025
Andrew Feldman, The Rt Hon the Lord Feldman of Elstree (volunteer for the Department of Health and Social Care, Chief Executive Officer and Chair of the Conservative Party from 2008 to 2016)	12 March 2025
Helen Whately MP (Minister of State for Social Care at the Department of Health and Social Care from February 2020 to September 2021)	13 March 2025
Sarah Collins (Commercial Director of Sourcing and Delivery for NHS Test and Trace from September 2020 to January 2022, Commercial Director at the UK Health Security Agency from January 2022 to January 2025)	13 March 2025
Dr Beverley Jandziol (Commercial Specialist in the Complex Transactions Team at the Cabinet Office from September 2019 to May 2022, deployed to the Department of Health and Social Care's Covid-19 National Testing Programme (which became NHS Test and Trace) from March to December 2020)	13 March 2025
Chris Stirling (Programme Director of the joint Department of Health and Social Care and NHS England and Improvement Covid Oxygen, Ventilation, Device and Clinical Consumable Response from March 2020 to September 2021, and Interim Director of Medical Technology from April 2021 to October 2022)	17 March 2025
Matthew Style (Director General of Secondary Care and Integration at the Department of Health and Social Care from November 2021)	17 March 2025
Professor Ramani Moonesinghe (National Clinical Director for Critical and Perioperative Care at NHS England from March 2020)	17 March 2025
Daniel Mortimer (Deputy Chief Executive of the NHS Confederation and Chief Executive Officer of NHS Employers, acting as Interim Chief Executive Officer of the NHS Confederation from October 2020 to June 2021)	18 March 2025

Witness (organisation)	Date of evidence
Rosemary Gallagher MBE (Professional Lead for Infection Prevention and Control and Nursing Sustainability at the Royal College of Nursing from July 2009 to July 2025)	18 March 2025
Paul Deighton, The Lord Deighton KBE (adviser on PPE to the Secretary of State for Health and Social Care from April to July 2020)	18 March 2025
Theodore Agnew, The Lord Agnew of Oulton DL (Minister of State at the Cabinet Office and the Treasury from February 2020 to January 2022)	18 March 2025
James Bethell, The Rt Hon the Lord Bethell (Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences at the Department of Health and Social Care from March 2020 to September 2021)	19 March 2025
The Rt Hon Matt Hancock (Secretary of State for Health and Social Care from July 2018 to June 2021)	19 March 2025
Tim Losty OBE (Director of International Relations in The Executive Office of Northern Ireland from 2012 to 2021)	19 March 2025
Richard James (Commercial Specialist in the Cabinet Office Complex Transactions Team and seconded to the Department of Health and Social Care's PPE Buy Cell (a sub-set of the PPE Cell) from March to June 2020)	20 March 2025 (closed hearing)
Max Cairnduff (Commercial Specialist within the Cabinet Office Complex Transactions Team from July 2018 to July 2023, High Priority Lane and Donations Lead in the PPE Buy Cell (a sub-set of the PPE Cell) from April to May 2020 and Director within the Complex Transactions Team from August 2020 to July 2023)	20 March 2025 (closed hearing)
Dawn Matthias (Caseworker on PPE procurement at the Department of Health and Social Care from March to July 2020)	20 March 2025 (closed hearing) 20 March 2025 (open hearing)
Jeane Freeman MSP OBE (Cabinet Secretary for Health and Sport in the Scottish Government from June 2018 to May 2021)	24 March 2025
Caroline Lamb (Director General for Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland from January 2021)	24 March 2025
Gordon Beattie (Director of National Procurement at NHS National Services Scotland (known from 1 April 2026 as Public Services Delivery Scotland) from December 2019)	24 March 2025
Paul Cackette CBE (Director of the PPE Directorate in the Scottish Government from April to June 2020)	24 March 2025
Chris Young (Director of Finance at the Department of Health and Social Care from January 2017 to October 2021)	25 March 2025

Witness (organisation)	Date of evidence
Andrew Slade (Director General, Economy, Skills and Natural Resources in the Welsh Government from January 2018 to April 2022, and Director General, Economy, Treasury and Constitution from April 2022 to March 2024)	25 March 2025
Jonathan Irvine (Director of Procurement Services at NHS Wales Shared Services Partnership from September 2019)	25 March 2025
Richard Davis (Senior Welsh Government representative of the Critical Equipment Requirement Engineering Team)	25 March 2025
Karen Bailey (Chief Executive of the Business Services Organisation)	26 March 2025
Chris Matthews (Deputy Secretary for Resources and Corporate Management at the Department of Health (Northern Ireland) from 2022)	26 March 2025
Conor Murphy MLA (Minister for Finance in Northern Ireland from January 2020 to October 2022)	26 March 2025
Major General Phillip Prosser (Brigadier Commander of the 101 Logistic Brigade deployed to the PPE team within NHS England)	26 March 2025
David Williams (Second Permanent Secretary to the Department of Health and Social Care from March 2020 to April 2021)	27 March 2025

Criticisms

A1.25. Rule 13(3) of the Inquiry Rules 2006 prevents the inclusion of any "*explicit or significant criticism*" of any person in this Report unless a warning letter has been sent and the relevant person has been given a reasonable opportunity to respond.[32] Warning letters were issued to persons identified in accordance with rule 13 and also with the Inquiry's Protocol on Warning Letters.[33] The Chair considered the responses to those letters before finalising this Report.

The Inquiry team

A1.26. The Chair was greatly assisted in Module 5 by the Inquiry team of counsel, solicitors, paralegals and other members of the Secretariat.

32 The Inquiry Rules 2006, rule 13(3) (https://www.legislation.gov.uk/uksi/2006/1838/contents/made)
33 'Inquiry Protocol on Warning Letters', UK Covid-19 Inquiry, 21 February 2025 (https://covid19.public-inquiry.uk/documents/inquiry-protocol-on-warning-letters)

Table 5: Module 5 Counsel team

Role	Name
Lead Counsel	Richard Wald KC
Junior Counsel	Jamie Sharma Tom Stoate Hannah Gardiner Victoria Shehadeh

Terminology and references

A1.27. The nature of the subject matter means that the evidence considered by the Inquiry contains technical and specialist language, which the Inquiry has tried to minimise in this Report. A number of witnesses and documents also used a range of abbreviations and acronyms. To avoid any confusion and to assist the reader, the Inquiry has set out names and other key phrases in full in this Report; a detailed glossary is also included at Appendix 2.

A1.28. Some terminology that is particularly key to understanding this Report is explained below for ease of reference.

Key terminology

A1.29. The virus that causes the coronavirus disease known as Covid-19 is SARS-CoV-2. However, where this specificity is not necessary, in accordance with the practice of the World Health Organization, the Inquiry uses 'Covid-19' to refer to both the virus and the disease.

A1.30. Although the first Covid-19 patients in the UK were announced on 31 January 2020 and the outbreak was not characterised by the World Health Organization as a pandemic until 11 March 2020, for clarity, this Report refers to the time period beginning with the arrival of Covid-19 in the UK as the 'Covid-19 pandemic'.

A1.31. The Covid-19 pandemic required action by both the UK government and devolved administrations. Wales, Scotland and Northern Ireland each have a legislature and executive elected by their own electorates (referred to in this Report as the 'devolved administrations'). Although each devolution settlement is different, each administration is responsible for a range of matters, including health, education and transport. England has no legislature of its own – instead, the UK Parliament legislates on both UK-wide, 'reserved' (ie not devolved) issues such as defence and foreign affairs and legislates for England on issues devolved to other nations. The UK Parliament also, at times, legislates for other groupings – for example, in England and Wales on issues of justice.

A1.32. 'The NHS' is the term used to refer collectively to the publicly funded healthcare systems in England, Scotland and Wales, comprising NHS England, NHS Scotland and the NHS in Wales (also known as 'NHS Wales'). In Northern Ireland, the publicly funded healthcare system is Health and Social Care (Northern Ireland), with health and social care integrated under a single framework.

References

A1.33. References such as 'Jonathan Marron 5 March 2025 123/3-8' or 'INQ000539153_0004 para 1' in the footnotes of this Report relate to material that is available on the Inquiry's website.[34]

A1.34. The transcripts of the Inquiry's hearings are referenced by person, hearing date, and internal page and line numbers. For example, 'Jonathan Marron 5 March 2025 123/3-8' refers to the evidence of Jonathan Marron on 5 March 2025, page 123, lines 3 to 8.

A1.35. Documentary evidence is referenced by the document's number and, where relevant, page and paragraph numbers. For example, 'INQ000539153_0004 para 1' refers to document INQ000539153, page 4, paragraph 1.

A1.36. Publicly available documents are listed in the footnotes with both their wider internet and Inquiry website links. For example:

> *Technical Report on the COVID-19 Pandemic in the UK*, Department of Health and Social Care, 1 December 2022, p190 (https://www.gov.uk/government/publications/technical-report-on-the-covid-19-pandemic-in-the-uk; INQ000101642).

34 'What is the UK Covid-19 Inquiry?', UK Covid-19 Inquiry, no date (https://covid19.public-inquiry)

Appendix 2: Glossary

Term	Description
Antibody	A component of the immune system that is produced after infection or vaccination with a pathogen and which identifies and helps to prevent future infections from the same pathogen.
Antibody testing	Detects antibodies to SARS-CoV-2 virus from a current or previous infection.
Arm's length bodies	A specific category of central government public bodies that are administratively classified by the Cabinet Office. There are three types of arm's length body: an executive agency, a non-departmental public body and a non-ministerial department.
Asymptomatic	Having an infection but not showing any symptoms.
Asymptomatic spread	When a person infected with a virus spreads it without ever developing symptoms.
Asymptomatic testing	The testing for diseases of individuals who show no symptoms but may still carry, transmit or develop complications from an infection.
Atamis	A procurement and contract management platform.
British Medical Association	A trade union and professional body for doctors and medical students in the UK.
British Safety Industry Federation	A trade association for the safety industry in the UK.
British Standards Institution	The UK's national standards body.
Bullwhip effect	A phenomenon in supply chains where small fluctuations in consumer demand cause progressively larger, amplified fluctuations in each subsequent stage of the supply chain, from retailers to manufacturers and suppliers.
Business consortium	An alliance of two or more independent entities pooling resources, knowledge or capital to achieve a common goal.
Business Services Organisation's Procurement and Logistics Service	An arm's length body of the Department of Health (Northern Ireland), which was the Centre of Procurement Expertise for the Department of Health (Northern Ireland). The provider of procurement and logistics services to all public health and social care organisations in Northern Ireland.
Cabinet Office	A ministerial UK government department, supported by 29 agencies and public bodies. It supports the Prime Minister, ensures the effective running of government and takes the lead in certain critical policy areas.
Cabinet Office Complex Transactions Team	A specialist unit within the Cabinet Office Government Commercial Function that provides commercial expertise and support for complex and high-value government transactions.
'CE' marking	A certification mark that is affixed to a product by a manufacturer, importer or authorised representative to indicate that the product complies with the relevant EU legislation.

Term	Description
Chancellor of the Duchy of Lancaster	A senior Cabinet Office minister and member of the Cabinet who administers the estates and rents of the Duchy of Lancaster. Responsible for overseeing all Cabinet Office policy, civil contingencies, resilience and national security.
Chancellor of the Exchequer	The UK government's chief financial minister, with overall responsibility for the Treasury.
Chief Medical Officer	A qualified medical practitioner, the most senior government adviser on health matters, and the professional head of all directors of public health in local government and the medical profession in government. There is a Chief Medical Officer for each of England, Wales, Scotland and Northern Ireland. The Chief Medical Officer for England is the UK government's chief medical adviser.
Chief Scientific Advisers	Senior science advisers, working in most government departments, who provide oversight and assurance of science capability and activities.
Clinical Countermeasures Board	A board chaired by the UK Health Security Agency consisting of representatives from a number of public health bodies across the four nations of the UK, with responsibility for providing governance and oversight of the maintenance and management of the clinical countermeasure UK stockpiles and the agreements required to ensure that the UK is well prepared to respond effectively to a pandemic.
Clipper Logistics plc	A UK-based logistics company specialising in retail and e-commerce logistics. Acquired by GXO Logistics in May 2022.
COBR	The UK government's national crisis management centre for responding to whole-system civil emergencies. It provides the coordination mechanism through which the UK government responds quickly to emergencies that require urgent decision-making. Its name was originally derived from its location in the Cabinet Office Briefing Rooms.
Comptroller and Auditor General for Northern Ireland	The head of the Northern Ireland Audit Office.
Consultancy Playbook	Guidance from the Cabinet Office on how to commission and engage with consultants more effectively to achieve better outcomes and value for money. Published on 5 September 2022.
Consumables	Items that are used up and need to be replaced on a regular basis.
Contact tracing	Identifying the source and contacts linked to a confirmed case of an infectious disease. A public health measure to contain the spread of an infection.

Term	Description
Contract award notice	A formal public announcement setting out key information about a public contract that has been awarded, including the date of the contract award, the supplier and the value of the contract.
Cost-effectiveness	The degree to which a product is effective or productive in relation to its cost.
Covid-19	The disease caused by the coronavirus, SARS-CoV-2.
Covid-19 Taskforce	Created at the end of May 2020 to provide strategic leadership on the response to Covid-19.
Department for Business and Trade	A ministerial UK government department established on 7 February 2023. It is the department for economic growth, which supports businesses to invest, grow and export, creating jobs and opportunities across the country.
Department for Business, Energy and Industrial Strategy	A former ministerial UK government department which was responsible for business, industrial strategy, science, research and innovation, energy, clean growth and climate change. It was abolished on 7 February 2023, when it was split into a number of other departments, including the Department for Business and Trade and the Department for Science, Innovation and Technology.
Department for International Trade	A former ministerial UK government department responsible for negotiating international trade agreements, promoting British exports and attracting foreign investment. It existed from July 2016 to February 2023, when it was merged with the Department for Business, Energy and Industrial Strategy to form the Department for Business and Trade.
Department of Health and Social Care	A ministerial UK government department with overall responsibility for health and care services. It sets strategy, funds and oversees the health and care system in England, with equivalent counterparts in the devolved nations. Known prior to January 2018 as the Department of Health – for clarity, the department is referred to throughout this Report using its current name.
Department of Health (Northern Ireland)	A devolved government department in the Northern Ireland Executive with a statutory responsibility to promote the physical and mental health and social wellbeing of people in Northern Ireland. Also responsible for the prevention, diagnosis and treatment of illness.
Devolution settlements	Settlements setting out the powers granted to the devolved legislatures (the Scottish Parliament, the Welsh Parliament and the Northern Ireland Assembly). Each devolved nation has its own devolution settlement.
Devolved administrations	The governments of Scotland, Wales and Northern Ireland.
Devolved nations	Scotland, Wales and Northern Ireland.

Term	Description
Directorate for Economic Development	A directorate of the Scottish Government with responsibility for developing Scotland's economy.
Disease X	An infectious disease that is currently not known to infect humans but could cause a serious epidemic or pandemic.
Efficacy	The extent to which a drug works as intended when it is tested in ideal circumstances such as in a controlled research study. Does not guarantee an identical level of effectiveness in real-world scenarios.
Emergency preparedness, resilience and response	Within a government department, the emergency preparedness, resilience and response function leads on the planning for and response to all incidents where there is a potential risk to public health.
Epidemic	A sudden increase in incidence of a disease that is higher than expected in a geographical region.
The Executive Office, Northern Ireland	A devolved Northern Ireland government department in the Northern Ireland Executive with principal policy responsibility for civil contingencies matters.
Exercise Alice	A February 2016 exercise to assess the challenges of a large-scale outbreak of Middle East respiratory syndrome coronavirus (MERS-CoV) in England.
Exercise Broad Street	A January 2018 exercise to develop an agreed approach to managing the end-to-end patient pathway for known and unknown high consequence infectious diseases and to ensure that a sustainable response was in place.
Exercise Cygnus	An October 2016 exercise assessing the UK's preparedness and response to a pandemic influenza outbreak.
Exercise Goliath	A December 2003 test of the response to a severe acute respiratory syndrome (SARS) outbreak in Northern Ireland.
Exercise Iris	A March 2018 exercise to assess Scotland's response to an outbreak of Middle East respiratory syndrome coronavirus (MERS-CoV).
Exercise Shipshape	A June 2003 exercise which was carried out following confirmation of the first case of severe acute respiratory syndrome (SARS) in the UK.
Export	The shipment of goods or delivery of services from one country to another.
Export controls	Restrictions on the shipment of goods or delivery of services from one country to another.

Term	Description
Filtering facepiece respirator (FFP)	A personal protection measure. FFP masks fit closely to a wearer's face and are designed to protect them by filtering out air particles, preventing inhalation of both large droplets and small aerosols. Graded from class 1 to class 3, with class 3 providing the highest protection.
Fit-testing	The process that a person wearing a respirator mask (such as an FFP mask) undergoes to ensure that the mask provides a sufficient seal around the nose and mouth to provide the wearer with the required protection.
Foreign, Commonwealth and Development Office	A ministerial UK government department, supported by 10 agencies and public bodies. Known prior to September 2020 as the Foreign and Commonwealth Office.
Foundry	The NHS national data platform introduced by NHS England in late April 2020.
Four nations	The four nations of the UK: England, Wales, Scotland and Northern Ireland.
Government Commercial Function	A cross-government network responsible for procuring or supporting the procurement of goods and services for the UK government. One of the Civil Service functions and part of the Cabinet Office.
Government Internal Audit Agency	An executive agency of HM Treasury. The UK government's primary provider of internal audit services.
Health and Safety Executive	Great Britain's national regulator for workplace health and safety, which monitors and enforces compliance with health and safety laws and regulations. The Health and Safety Executive for Northern Ireland is the equivalent regulator in Northern Ireland.
High consequence infectious disease	An acute infectious disease which: • can transmit in the community and may be difficult to detect rapidly; • typically has a high case fatality ratio (the percentage of people diagnosed with a disease who die from it) and few or no prophylactic or therapeutic drugs; and • therefore requires an enhanced individual, population and system response.
High Priority Lane	A team of officials established to triage offers to supply personal protective equipment (PPE) received by ministers and senior officials.
HM Treasury	A ministerial UK government department that acts as the economic and finance ministry, maintaining control over public spending and setting the direction of UK economic policy.

Term	Description
Home Office	A ministerial UK government department, supported by 30 agencies and public bodies. The lead government department for immigration and passports, drugs policy, crime, fire, counter-terrorism and police.
Immunity	The ability to defend the body from a pathogen's infection. Acquired immunity describes how the body builds immunological memory – so that if the person is exposed to the same infection again, the body's response is enhanced. This is the basis for immunisation with vaccines.
Infection prevention and control (IPC)	Measures which aim to stop a virus from spreading in a particular environment or to inactivate it so that it cannot cause an infection.
Influenza (flu)	A viral respiratory infection that infects humans and several other host species globally. It causes both seasonal endemic waves of infection and, when new strains emerge against which the population has less immunity, may cause more severe epidemics or pandemics.
Intensive care unit	A type of hospital ward that provides specialised care for critically ill patients, such as mechanical ventilation for respiratory failure.
Interventions	Any activity undertaken with the objective of improving human health by preventing disease, by curing or reducing the severity or duration of an existing disease, or by restoring function lost through disease or injury.
Just-in-time	A stock control method that emphasises keeping inventory to a minimum and using short-term, flexible contracts that can be adjusted quickly to changes in demand.
Lateral flow test	A type of molecular test to detect an active infection. These tests do not require processing in a laboratory and results are available within minutes.
Lead government department	The government department responsible for leading work to identify particular risks, and ensuring that the right planning, response and recovery arrangements are in place.
Life Sciences Hub Wales	An arm's length body of the Welsh Government responsible for identifying health innovation opportunities for the health and social care sectors in Wales.
Lighthouse Laboratories	Network of laboratories set up to perform Covid-19 testing for NHS Test and Trace.
Local authority	An administrative body in local government that provides public services in a local area.
Local Government Association	A national membership body for local authorities in England and Wales.

Term	Description
Lockdown	A mandatory stay-at-home order, a legal prohibition placing blanket restrictions on the whole population (apart from specified activities) for the purpose of limiting the spread of a disease.
Market surveillance	The suite of activities that helps protect citizens from non-compliant and unsafe non-food products.
Mass testing	Using tests in a large number of asymptomatic people to detect those who are infected.
Medical devices	A medical device is any instrument, apparatus, appliance, software, material or other article, which is intended for human use, that performs a medical purpose, such as diagnosing, monitoring or treating a medical condition.
Medicines and Healthcare products Regulatory Agency (MHRA)	An executive agency of the Department of Health and Social Care. It regulates medicines, medical devices and blood components used in transfusions in the UK. It decides whether to approve new medicines such as vaccines.
Medicines Optimisation Innovation Centre	A regional research and development body in Northern Ireland.
Memorandum of Understanding	A non-legal agreement between two or more parties usually set out within a formal document.
Middle East respiratory syndrome (MERS)	The disease caused by Middle East respiratory syndrome coronavirus (MERS-CoV).
Modelling	Statistical models are tools for analysing complex data, identifying patterns, and informing evidence-based decision-making where direct measurement is not possible. Figures from modelling are estimates only, and different statistical models will produce different outcomes. These estimates are not based on direct observations. They are therefore limited by the underlying assumptions used in the models and are subject to uncertainty.
National Audit Office	The UK's independent public spending watchdog. The National Audit Office supports Parliament in holding government to account and helps improve its high-quality audits. It is independent of government and the Civil Service.
National Manufacturing Institute Scotland	An industry-led centre of manufacturing expertise based in Scotland.
National Risk Register	A public-facing version of the National Security Risk Assessment, aimed at providing detailed information for those with formal contingency planning responsibilities at a national and local level.

Term	Description
National Security Risk Assessment	The main tool for assessing the most serious civil contingency risks facing the UK. It assesses, compares and prioritises the top national-level risks, focusing on both the likelihood of the risk occurring and the impact it would have.
National Ventilation Allocation Panel	A panel established by NHS England to manage the allocation and distribution of mechanical ventilators during the Covid-19 pandemic.
New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG)	An expert scientific committee of the Department of Health and Social Care which advises the Chief Medical Officer and, through them, the UK government. It provides scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management.
NHS	The term used to refer collectively to the publicly funded healthcare systems in England, Scotland and Wales, comprising NHS England, NHS Scotland and the NHS in Wales (also known as 'NHS Wales'). The publicly funded healthcare system in Northern Ireland is Health and Social Care (Northern Ireland).
NHS England	An executive non-departmental public body, sponsored by the Department of Health and Social Care, that leads and oversees the NHS in England. It is responsible for the operation of the NHS in England and for implementing healthcare strategy developed by the Department of Health and Social Care.
NHS in Wales (NHS Wales)	The NHS in Wales is made up of local health boards, trusts (including Public Health Wales) and special health authorities (Health Education and Improvement Wales and Digital Health and Care Wales). The local health boards are responsible for planning, securing and delivering all healthcare services for the benefit of their resident population in a specific geographical area. The term 'NHS Wales' is commonly used to refer collectively to local health boards, trusts and special health authorities in Wales, though there is no central legal entity with this name.
NHS National Services Scotland	NHS Scotland's former national procurement service. From 1 April 2026, NHS National Services Scotland was merged with NHS Education for Scotland to form a new national organisation, Public Services Delivery Scotland.
NHS Scotland	The publicly funded healthcare system in Scotland, made up of geographical health boards and non-geographical special boards, and supported by NHS National Services Scotland (known from 1 April 2026 as Public Services Delivery Scotland) and Healthcare Improvement Scotland.

Term	Description
NHS Test and Trace	A service set up in May 2020 as part of the Department of Health and Social Care to provide Covid-19 testing and contact tracing. Working with local authorities, it contacted people who had tested positive and their recent contacts to advise them to self-isolate, as well as providing telephone monitoring and support.
NHS trusts	NHS trusts can run multiple hospitals and community sites, and provide healthcare (including within the community), mental health services and ambulance services.
NHS Wales Shared Services Partnership	An independent mutual organisation owned and directed by NHS Wales to provide a range of customer-focused support functions and services to NHS Wales.
Northern Ireland Audit Office	An independent public body that audits central government departments, agencies and local councils in Northern Ireland.
Northern Ireland Executive	The Northern Ireland Executive is the administrative branch of the Northern Ireland Assembly, the devolved legislature for Northern Ireland. It is responsible for matters including enterprise, trade and investment, agriculture and rural development, education, health, policing and justice, environment and regional development.
Office for Product Safety and Standards	The UK's national product regulator within the Department for Business and Trade.
OneWorld	A specialist IT system to track the progress of shipments.
Outbreak	The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.
Oxygen, Ventilation, Medical Devices and Clinical Consumables Programme	A programme jointly run by the Department of Health and Social Care and NHS England to procure ventilators, oxygen and related critical care equipment.
Pandemic	An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.
Pathogens	Infectious organisms, such as viruses, bacteria or parasites, that can produce a disease.
Permanent Secretary	A senior civil servant responsible for the day-to-day running of a government department. In the UK government and in Northern Ireland, there is a Permanent Secretary for each government department. There is a single Permanent Secretary for each of the Scottish and Welsh Governments.
Personal protective equipment (PPE)	Equipment that minimises exposure to hazards. In health and social care, it ranges from basic items such as aprons, gowns and disposable gloves to specialised items such as face shields and respirator masks.

Term	Description
Polymerase chain reaction (PCR) test	A specialised laboratory method used to increase the amount of DNA (deoxyribonucleic acid) or RNA (ribonucleic acid) in a sample so that there is enough to test it. PCR tests are used to detect RNA in samples from people to see if the samples contain SARS-CoV-2 virus.
PPE Cell	Established by the Department of Health and Social Care in March 2020 to centralise PPE procurement, the PPE Cell was a group of dedicated teams and officials responsible for procuring and distributing PPE.
Preparedness and resilience	The extent to which the UK government and devolved administrations were ready for, and could withstand and adapt to, an emergency such as the coronavirus (Covid-19) pandemic.
Prime Minister of the UK	The leader of the UK government, ultimately responsible for the policy and decisions of the UK government.
Project Defend	A UK government project commissioned in April 2020 by the Prime Minister to investigate vulnerabilities in supply chains for essential goods.
Public health	The science and art of preventing disease, prolonging life and promoting health through organised efforts of society.
Public Health Agency (Northern Ireland)	Established under the Health and Social Care (Reform) Act (Northern Ireland) 2009. Responsible for the improvement of health and social wellbeing, reducing health inequalities in Northern Ireland, health protection and service development.
Public Health England	An executive agency of the Department of Health and Social Care responsible for all aspects of public health, replaced by the UK Health Security Agency and Office for Health Improvement and Disparities in October 2021.
Public Health Laboratory Service	Established with the NHS in 1948 and oversaw a network of local, regional and national laboratories. Abolished in 2003 when its functions were taken over by the Health Protection Agency.
Public Health Scotland	Scotland's national public health body, working to prevent disease, prolong healthy life and promote health and wellbeing. Preceded prior to 1 April 2020 by Health Protection Scotland.
Public Health Wales	An NHS trust which aims to protect and improve health and wellbeing and reduce health inequalities in Wales.
Public procurement	The process by which governments and public bodies buy goods and services.
Public Services Delivery Scotland	The Scottish public sector's enabler of transformation, digital innovation, workforce development, education, training and Once for Scotland services. Established on 1 April 2026, replacing NHS Education for Scotland and NHS National Services Scotland.

Term	Description
Regulations	A type of secondary legislation.
Restriction order	An order made by the Chair of an inquiry under section 19 of the Inquiries Act 2005 to restrict disclosure or publication of any evidence or documents, or attendance at an inquiry or any part of an inquiry.
Risk	The possibility of a harmful event. In the context of civil emergency preparedness and resilience, an event, person or object that could cause loss of life or injury, damage to infrastructure, social and economic disruption or environmental degradation.
Risk assessment	A systematic process for evaluating the likelihood of a potential risk occurring and the potential impact it would have, were it to happen.
Royal College of Nursing	A nursing union and professional body.
Scientific Advisory Group for Emergencies (SAGE)	An advisory group convened to provide independent scientific advice to support decision-making in COBR in the event of a national emergency.
Scottish Enterprise	A non-departmental public body of the Scottish Government. Scotland's national economic development agency.
Scottish Government	The devolved administration for Scotland.
Secretary of State	A Cabinet minister in charge of a government department.
ServiceNow	A cloud computing platform.
Shielding	An intervention introduced to support those who are clinically extremely vulnerable and therefore considered to be most at risk of serious illness from, for example, Covid-19.
Social enterprise	A business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners.
Stockpile	An accumulation of goods, supplies or resources, by governments, beyond immediate needs to prepare for expected shortages, lockdowns or emergency situations – for example, a pandemic.
Supply Chain Coordination Ltd	A UK-based company that was wholly owned by the Department of Health and Social Care until 1 October 2021, when it was transferred to NHS England. It provides oversight and operational management for NHS Supply Chain and is the legal entity through which NHS Supply Chain undertakes its procurement services and transacts with customers and suppliers.
Swine flu	A relatively mild influenza pandemic, which began in 2009.
Transmission	The process by which a pathogen, such as a virus, spreads from one infected person to another.

Term	Description
UK government	The central government for the UK, headed by the Prime Minister. The UK government is responsible for non-devolved policy matters across the UK. (The Scottish Government, Welsh Government and Northern Ireland Executive are separate from the UK government and are responsible for devolved policy matters in their respective nations.)
UK Health Security Agency (UKHSA)	An executive agency, established in April 2021 and sponsored by the Department of Health and Social Care, responsible for public health protection and infectious disease capability.
UK Infection Prevention and Control Cell (UK IPC Cell)	A body created with the intended purpose of ensuring that a coordinated approach was taken to infection prevention and control guidance for Covid-19 across the UK. It consisted of representatives from NHS England, the public health bodies in England, Northern Ireland and Wales, Antimicrobial Resistance and Healthcare Associated Infection Scotland, the Scottish Government Healthcare Associated Infection Policy Unit, the Association of Ambulance Chief Executives and the Department of Health and Social Care.
UK Influenza Pandemic Preparedness Strategy 2011	The UK's emergency response strategy for dealing with an influenza pandemic.
Unipart	A specialist logistics company contracted prior to the Covid-19 pandemic by the UK government to supply its services in the event of an emergency.
Uniserve	A UK-based supply chain and logistics company.
Vaccination	Protecting individuals from a disease by administering a vaccine.
Vaccine	Vaccines train the immune system to recognise a pathogen and to produce antibodies to defend the body from it at the next encounter.
Variant	As a virus replicates, it can accumulate mutations. A version of the virus with these mutations is called a 'variant'. Mutations may facilitate transmission or impact the effectiveness of vaccines, treatments or immunity resulting from previous infection.
Ventilation	The process of introducing fresh air into indoor spaces while removing stale air.
Ventilator	A life support machine used to support breathing by mechanically pumping air into a patient's lungs.
Ventilator Challenge	A UK government initiative asking companies to help manufacture, design and build ventilators during the Covid-19 pandemic.
Virology	The scientific and medical discipline concerned with understanding the biology of viruses and viral diseases, their treatment and prevention.

Term	Description
Virus	A parasitic infectious agent that replicates only inside the cells of an organism.
Welsh Government	The devolved administration for Wales.
Welsh Government Commercial and Procurement Directorate	The directorate of the Welsh Government responsible for managing and overseeing the Welsh Government's procurement responsibilities.
World Health Organization (WHO)	A specialised agency of the United Nations responsible for international public health.

Appendix 3: List of recommendations

Chapter 1: The UK's readiness for emergency procurement and distribution

Recommendation 1: Improvements to the composition, management and inspection of the pandemic stockpiles

The UK government and devolved administrations should ensure, within 12 months of the publication of this Report, that the pandemic stockpiles:

- retain stock that is better aligned with the range and severity of pandemic risks identified in the National Security Risk Assessment;
- maintain a minimum three-month supply of PPE for the entire health and social care system in the UK;
- retain close-to-zero tolerance for expired stock;
- better reflect the composition of the UK's health and social care workforce, aligned with fit-testing and other sizing requirements;
- maintain a simple and streamlined system of management and oversight; and
- are stored in a wide range of accessible locations.

To demonstrate continued compliance with the above, inspection reports should be submitted to health and social care ministers at least annually. Any issues identified should be resolved within three months.

The inspection reports should be published with the preparedness and resilience reports (Module 1, Recommendation 8).

Recommendation 2: Pandemic response exercises to include emergency procurement and distribution

The UK government and devolved administrations should evaluate the readiness of the structures, systems and processes for the emergency procurement and distribution of healthcare equipment as part of UK-wide pandemic response exercises.

Chapter 2: Emergency procurement and distribution during the pandemic

Recommendation 3: Emergency procurement and distribution systems for the UK

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive, within 12 months of the publication of this Report, should each have ready systems for the emergency procurement and distribution of healthcare equipment.

These new systems must:

- integrate procurement and distribution;
- have the ability rapidly to scale up efficient operations, including through integrated emergency procurement teams and automating the triaging and processing of offers of supply; and
- be able to use market research, modelling and price benchmarking to ensure value for money.

Chapter 3: Regulation, inspection and enforcement

Recommendation 4: Emergency healthcare equipment regulations

The UK government and devolved administrations should publish simplified regulations for emergency healthcare equipment that are aligned with and cover the range and severity of pandemic risks identified in the National Security Risk Assessment.

The simplified regulations should:

- establish the minimum technical specifications of healthcare equipment specifically for use in a pandemic, including international standards that are recognised in the UK;
- clearly identify the regulator responsible for coordinating regulation, inspection and enforcement for each type of equipment; and
- be accompanied by a buyer's guide that is easily understood by procurement officials, suppliers and end-users in the health and social care sectors.

The emergency healthcare equipment regulations and the buyer's guide should be kept under review and updated in line with relevant changes to the National Security Risk Assessment.

Recommendation 5: An emergency healthcare equipment plan

UK regulators, including the Health and Safety Executive, the Health and Safety Executive for Northern Ireland, the Office for Product Safety and Standards and the Medicines and Healthcare products Regulatory Agency, should establish an emergency healthcare equipment cross-regulator plan for future pandemics.

The plan must include arrangements for:

- coordination of written guidance from regulators to ensure that it is clear, concise and updated when required; and
- increasing testing house capacity and the deployment of suitable inspection regimes both to reduce the quantity of non-compliant equipment entering the system and to improve enforcement.

Chapter 4: Global supply chains and domestic industrial resilience

Recommendation 6: Blueprints for critical care medical technology

The UK government and devolved administrations should jointly commission a group of experts to develop blueprints for rapidly scalable critical care medical technology, aligned with the range and severity of pandemic risks identified in the National Security Risk Assessment, within 12 months of the publication of this Report.

The blueprints should be issued in accordance with the emergency healthcare equipment regulations and buyer's guide (see Recommendation 4 of this Report) and regularly reviewed to ensure that they reflect technological advances.

Recommendation 7: Emergency international trade and domestic industry to form part of the whole-system civil emergency strategy

The UK-wide whole-system civil emergency strategy, which the Inquiry has recommended should be developed by the UK government and devolved administrations (see the Inquiry's Module 1 Report, Recommendation 4), should include specific objectives for international trade and domestic industry during a pandemic.

These must include:

- the establishment of trading alliances in advance of the next pandemic, to diversify overseas sources of raw materials and healthcare equipment;
- contractual arrangements with domestic and international suppliers of raw materials and healthcare equipment manufacturers which activate when a pandemic is declared;
- a robust plan to enable domestic manufacturers rapidly to retool and repurpose facilities for the production of healthcare equipment; and
- supporting investment for research and development into advanced manufacturing of healthcare equipment in the UK.

Chapters 5 and 5A: Procurement and distribution expertise and experience

Recommendation 8: A programme of training in emergency procurement and distribution of healthcare equipment

The UK government and devolved administrations should each establish a pool of officials who are trained in the emergency procurement and distribution of healthcare equipment.

Completion of the training should be mandatory for at least 20% of the workforce of each nation's central healthcare equipment procurement bodies and kept up to date through annual refresher courses.

Recommendation 9: A commercial framework agreement for the emergency procurement and distribution of healthcare equipment

The UK government and devolved administrations should collaborate to establish a UK-wide commercial framework agreement of pre-approved external specialists in the emergency procurement and distribution of healthcare equipment.

The framework should be refreshed every three years.

Chapter 6: Transparency, governance and accountability

Recommendation 10: Improved transparency, governance and accountability in an emergency

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should improve transparency, governance and accountability for procurement in an emergency.

As a minimum, these improvements should include the following:

Enhancing transparency

- Any central digital platform used for procurement must allow for the automated collation of contract information and must reduce the administrative burden involved in publishing contract information.
- Contracting authorities across the UK should be required to publish contract award notices (in Scotland) and contract details notices in addition to contract award notices (in England, Wales and Northern Ireland) irrespective of the country in which the supplier is based.

Governance: Fairness in emergency procurement

- There should be no high priority lane.
- All offers to supply healthcare equipment during a pandemic should be assessed according to the application of objective criteria.

Accountability: Approval process for emergency spending on healthcare equipment

- In advance of a pandemic, each health and social care department in each government should agree, with their respective treasuries or finance departments, a process to scrutinise and approve emergency spending on healthcare equipment to ensure that there is a balance between accountability and timely spending decisions.

Chapter 7: Data, technology and the future of emergency procurement

Recommendation 11: Placing data and technology at the centre of emergency procurement and distribution of healthcare equipment

Within three years of the publication of this Report, the systems for the procurement and distribution of healthcare equipment should be digitalised and interoperable across the UK government and devolved administrations.

As a minimum, these systems should be able to use technology to collect, share and analyse data across the UK in real time on:

- pandemic stockpiles, health and social care sector inventories and usage rates;
- offers of supply, enabling automated comparison, triaging and processing;
- non-compliant healthcare equipment entering the market;
- supply chains, including international delivery times and domestic logistics and distribution data;
- procurement and distribution workforce capacity; and
- spending – automatically identifying, collecting and collating key contract data for publication.

UK
Covid-19
Inquiry

978-1-5286-6581-0

E03444965