Week Two Summary of Evidence

Witnesses

1. Professor John Manners-Bell (Inquiry Expert – Supply Chains)
2. Andrew Mitchell (on behalf of the former Department for International Trade DIT),
3. Simon Manley CMG (on behalf of the Foreign, Commonwealth and Development Office)
4. The Rt Hon Michael Gove (Former MP and Chancellor of the Duchy of Lancaster)
5. Dr Dame Emily Lawson (on behalf of NHS England)
6. Paul Webster (Executive Director of Governance and Legal, Company Secretary of Supply Chain Coordination Ltd)
7. Julian Kelly (Chief Financial Officer NHS England)
8. Alan Brace (Director of Finance of the Health and Social Services Group, Wales)
9. Tim Jarvis (on behalf of the former Department for Business Energy and Industrial Strategy, BEIS)
10. Graham Russell (Office for Product Safety and Standards)
11. The Rt Hon Steve Barclay (Former Chief Secretary to HM Treasury)
12. The Rt Hon Lord Feldman of Elstree (Former Adviser to the Department of Health and Social Care)
13. Helen Whately (MP for Faversham and Mid Kent and Former Minister of State for Care, DHSC)
14. Sarah Collins (on behalf of the UK Health Security Agency, UKHSA)
15. Dr Beverley Jandziol (Former Commercial Specialist, Complex Transactions Team)

Professor John Manners-Bell (Inquiry Expert – Supply Chains)

Delivering PPE stock to local health boards did not necessarily mean it reached the right hospital or the right ward. Not getting the PPE to the right place means a critical supply chain failure. The change in government guidance on the frequency of use of PPE in medical settings, leads to huge volatility in demand. Supply chains work best in a more stable environment. Supply chains worked very well at times of stability but they need the flexibility and agility to work in times of emergency,

The supply chain and the logistics in the UK just weren't able to cope with the demands which were being placed upon them. The systems were not set up, whether they were the warehousing systems or whether they were the procurement systems. The framework system which had been set up by the NHS Supply Chain wasn't able to cope with the demand either.

There were certainly preparations put in place but they weren't anywhere near to being sufficiently robust enough to deal with the demand of the pandemic. A global shortage of pandemic was not taken into account. Nobody, as far as I am aware, looked at the possibility that there would be a global constraint of PPE.

There is a huge fragmentation of data relating to inventory. There was no way of tracking what the individual trusts had and there was no way of tracking what the individual products were that were being bought. If you don't manufacture in the UK, there is always a very significant political risk to supply in a

pandemic. Diversification is absolutely critical. Looking at multiple countries outside of China is a first step.

We need a multi-faceted approach to building resilience in supply chain. if you have those long-term relationships in place, there is a smaller likelihood that when there is stress, that those manufacturers will be driven by short-term benefits from the price of PPE. But the only way you could absolutely ensure that you had supplies of PPE would be to develop onshore manufacturing within the UK.

The offshoring trend goes back two, three, four decades now. It's not just the labour but a lot of the knowhow, the experience has been lost. If you lose that ability, then it will take a generation to build that back up starting from scratch.

Andrew Mitchell (on behalf of the former Department for International Trade DIT),

The DIT became the frontline of procurement for PPE on behalf of the Department of Health and Social Care in in markets around the world. In order for those teams in markets overseas who had no particular experience of medical supplies and medical supply chains to be able to do the job that we were asking, we clearly needed quite detailed specifications for the medical equipment required. The level of technical specification was not to the degree that we required, and this was a known issue. We rectified that, the Department of Health and Social Care acted on that requirement relatively quickly, but at the early stages this was a factor.

Had commercial expertise been deployed earlier there would have been a much better commercial process, end-to-end, which would have been to the benefit of DHSC in allowing them then to manage the backlog more effectively. We should have spotted that at an earlier stage.

In respect of ventilators the guidance instructed officials conducting triage to be cautious of new suppliers entering the market and claiming to have stock. This was due to an increase in intermediaries offering stock on behalf of companies. The experience of the team in China on the ground was that sources of supply were much more reliable when they went direct to the manufacturers. The product supplied via intermediaries was likely to be harder to verify. The issue was that new suppliers were coming on to the market and they were essentially untested.

Simon Manley CMG (on behalf of the Foreign, Commonwealth and Development Office)

I became DG on 16th March 2020 so just after the initial requests out for No 10 on 14 March for help in securing ventilators so my first day in the job was dominated by this challenge. We went to DHSC to get the specifications of what they were looking for. Then we wrote out to contacts in our network to identify potential suppliers of ventilators.

We were aware that intermediaries were not necessarily a particularly helpful avenue down which to go, because in many cases, it turned out that you were dealing with somebody who was in turn dealing with

the very company that we were already dealing with. But we wanted to ensure we were not neglecting a potential opportunity, so there was a tension there.

The Rt Hon Michael Gove (Former MP and Chancellor of the Duchy of Lancaster)

Professor Sanchez-Graells seems profoundly to underestimate the degree of pressure under which this and other governments were placed at the beginning of the pandemic. The point by Prof Sanchez-Graells is that even during times of emergency the rules of fairness and transparency must apply. In fact they become even more crucial in a crisis because that is when a government is at greater risk of being taken advantage of as unscrupulous people look to take advantage of the emergency.

Statement: I did not have any direct decision-making authority or leadership, with the exception of the Ventilator Challenge.

Boris Johnson: *Dyson freaking. Action this day*

Matt Hancock: *I have received the same. I will talk to Dyson and Michael and sort it.*

I was certainly informed at different points of the frustrations that Sir James Dyson felt with the process. I did not have as much direct involvement with any other potential ventilator manufacturer as I did with Dyson. It was the case that Sir James was frustrated at what he perceived to be bureaucratic slowness on the part of the government machine. Part of my role was to challenge the bureaucracy within the government machine at every point, not just on behalf of Sir James but on behalf of the National Health Service and those at the frontline.

Sir James, because of his production facilities, had his prototype got through testing, would have been able to produce significant numbers. I was aware at the time Sir Gareth Rhys Williams had significant concerns about the safety of the ventilator prototype being proposed by Dyson. The reason I pressed was to see if it was possible to refine the design and indeed the design was refined, and some but not all of the obstacles to its implementation were addressed. But throughout, we were very clear that no device should be deployed on the frontline unless it had secured approval from the MHRA.

I could not tell the MHRA what to approve and would not do so. It's absurd to imagine that I or any other minister could instruct the MHRA, an independent regulatory agency, to approve a product.

Email from Graham Tunbridge from MHRA: Chancellor of the Duchy of Lancaster did not appreciate the level of risk involved in the manufacture and use of ventilators and wanted to circumvent the expedited regulatory process that has been put in place."

Gove claims he wanted to see the process accelerated rather than circumvented which is the impression MHRA had.

I am not an expert, the MHRA are, in deciding whether or not a prototype is suitable for deployment. What I do have experience of is pushing bureaucracy and sometimes I can be unreasonable.

John Manzoni: *"I can recall that I was concerned that, by virtue of the meeting being called by CDL, indirect pressure was being placed on the MHRA, indirect pressure, to approve the suppliers' design. I felt I had to and did intervene in this meeting to ensure that the MHRA approval system, as the regulatory system, was properly applied and to protect the integrity of the process."*

I do not agree that such a need did arise. I have no regrets in the way it was handled.

I was made aware of the VIP Lane via the media. The VIP Lane was found to be unlawful but the judgment concludes that the contracts would have been awarded to those respective bidders in any case. This ignores the point that Prof SG made which is that tax payer money was spent unlawfully. I acted as postman, I didn't seek to assess the offers I passed on. In most cases the people who would contact me appeared to be businesses that were capable of operating effectively. The High Priority Lane would then conduct an initial assessment and then after that there were two more processes that had to go through.

Meller Designs: David Meller is a great personal friend. He did financially support my bid to become the Conservative Party leader. My Private Office was told and was aware that he was a friend of mine, and that he had donated money to my political campaigning activity in the past, and therefore that any approach should be approached with particular care in other words, he should not be favoured. I was not aware that the price being asked by DM was approximately twice the going rate.

Dr Dame Emily Lawson (on behalf of NHS England)

10th March, NHS England's chief executive asked me to investigate complaints from NHS trusts that their orders for PPE were not arriving on time. The whole PIPP stock hadn't been released, it was happening in a controlled way. The PPE stockpile was in the warehouse in Haydock. You don't go into that kind of warehouse to send a couple of pallets to a trust; it has to come out of that warehouse into the distribution warehouse and then it can be dispatched to trusts.

The use of FFP3s had gone up by threefold by the end of February. There was a release of some stock from Haydock but PHE and the SCCL were concerned not to release that all at once, because it might need to last for longer.

The thing that I found most difficult is SCCL could not tell me how much additional stock they'd bought. I knew they'd placed additional orders, but they couldn't tell me how much and they also had didn't know when these orders would arrive. We might have already increased buying but we didn't know when it would come. I didn't feel like SCCL gave me confidence that collectively we're going to solve this problem.

We concluded that SCCL could not cope with PPE storage, processing, and distribution. That was the genesis of the Parallel Supply Chain. We had reached the limits and in fact gone beyond the limits of the existing system. We had maxed out the warehouse and shipping capability.

There was an urgent need for some form of prioritisation and tracking of those offers. There were two things that we desperately needed to do. The first was to triage offers and find the ones that were technically qualified and deliverable. The second was to get back to people and to run a professional

operation, because that was essential to confidence of ministers, but more importantly, confidence of the public.

I asked Hannah Bolton to do the first task. Hannah's email inbox very quickly got overwhelmed with people wanting responses. In retrospect it resulted in what eventually became the HPL. I don't know that we could have predicted that on 21st March.

The Cabinet Office team took massive responsibility immediately for sorting out the additional buying and in fact within a week they also took over the PPE elements from SCCL, because it had got too much for SCCL to continue to run separately. That was the right decision.

At the start of the pandemic most Trusts had some kind of what's called an Inventory Management Tool which were fairly basic but they couldn't talk to SCCL or to NHS England. So, we built a system from scratch and that was in place from May. Now, all Trusts have improved inventory management systems, about 130 have a system that can effectively talk to SCCL if needed, and the plan is to continue to roll that out. So partly thanks to what we did during the pandemic, that has move on dramatically.

The UK ended up with just shy of 7 billion items of excess PPE.

Paul Webster (Executive Director of Governance and Legal, Company Secretary of Supply Chain Coordination Ltd)

Prior to the pandemic, PPE was a tiny fraction of the products we purchased. We were responsible for some of the purchasing of the products that went into the stockpile, albeit that we weren't responsible for deciding what those products should be.

Products have 60-month shelf life from the point of manufacture. It is also possible to extend the shelf life of products for up to 10 years. Extending their shelf life beyond the current shelf life is largely done by the manufacturers to provide their own confirmation that that product remains fit for purpose for an additional period. It voids a need to take stuff out of the stockpile and then buy new in. it's a case of active stock management.

We have a finite number of warehouses and a finite number of warehouse lorries to do deliveries, and we were only ever set up to deliver products to 240 NHS trusts. Being asked then to deliver PPE in volumes that were so significant and then ultimately to 58,000 locations is just not sustainable.

One of the ways SCCL responded to the demand was by demand management. In simple terms, cancelling down orders placed by NHS Trusts. There was no centralised information on inventories, so SCCL couldn't know how much stock was held, whether an order was as a buffer for immediate use, by any given NHS trust. That's one of the biggest problems we faced, knowing if somebody was ordering a thousand, did they already have 1,000 in stock, or was it because they had absolutely none? Knowing where stock was and how much stock existed was impossible.

Trusts were informed, both by the Department and others, not to stockpile

Julian Kelly (Chief Financial Officer NHS England)

Normally hospitals are autonomous organisations making their own decisions, but in a level 4 incident, we will take responsibility for giving stronger direction to NHS providers on certain issues. Where we think new capacity needs to be put in place, or we want to enhance staffing, we will give a stronger instruction.

We were asking people what the supplies of their PPE were at that point in time, have you exercised your staff for was a High Consequence Infectious Disease which has certain protocols. Have you briefed your staff? Do you have adequate supplies?

In the middle of February the Department, PHE and SCCL agreed to put some limits on what orders are fulfilled to manage the stock. NHS England was saying on 2 March to ensure you have enough stock for 2-3 weeks, don't create very large stocks.

Alan Brace (Director of Finance of the Health and Social Services Group, Wales)

Chaired the PPE sourcing and distribution group between June and September as there were growing concerns about PPE. There were two main challenges: buying replacement product and distributing the product that we had. The only issue with out-of-date PPE stock that I was aware of was stock that was sent out after being retested for suitability and redated, but not all the stock had been redated.

Elements of the social care system within the private sector had made their own arrangements. The local authorities didn't collectively purchase PPE. They had spread their procurement expertise quite thinly amongst the 22 local authorities, so there was no central capability to do very much in relation to PPE. So that's why the shared service took over social care.

There was a disconnect between what Shared Service believed it had pushed out to the NHS and what the NHS believed they had. We didn't really have any significant capacity to spend a lot of time on this so the military seemed to be an obvious choice to quickly try to understand what the issues were. They confirmed that there was enough stock out there. Clearly there were coordination issues at the hospital end about what stock was held where, and how to distribute that as quickly as possible across the various sites.

I was not aware at any time that Wales had ran out of PPE. On 2 April Military said we had not run out but there was a problem with distribution.

Tim Jarvis (on behalf of the former Department for Business Energy and Industrial Strategy, BEIS)

There was very little PPE manufactured in the UK at that point, and there was the view was that there was capacity within the UK manufacturing sector that could meet some of the demand that we were struggling to fulfil from other sources.

The UK Make team was led by Lord Deighton who, on 19 April of 2020 was appointed by the then Secretary of State for Health and Social Care, to lead the national effort to produce PPE. I was appointed to the PPE Make Programme on around 27 or 28 April of 2020. I was to coordinate the end process with end-to-end process with domestic manufacturers and feed them into the 8 stage process.

The criteria in very broad terms would have been about the ability to produce at scale and at pace. That would have been the driving factor. Obviously, there would be a process to ensure that those contracts were value for money in the context of the market that we were operating in at the time.

In normal time there was quite a long lead in time for regulatory approvals. That process didn't work in the period that we were operating in because we needed to get people manufacturing very quickly. So the challenge was to try to make that process as smooth as possible and to speed it up so that we could, rather than having this long front end before companies could start manufacturing, we could expedite that and get companies manufacturing in time to meet the demand that we had.

There was never any question of there being any compromise on the quality of the products and the standards it needed to meet. We worked to accelerate those processes for example, where different regulatory bodies might have a decision to make in relation to the same product, that that could happen simultaneously rather than over time, which I think was what would usually happen.

Graham Russell (Office for Product Safety and Standards)

MHRA is the lead authority in medical products, HSE is the markets defence authority for PPE in the workplace and Trading Standards is the market clear leader authority for consumer PPE or PPE outside the workplace.

One of the roles that OPSS took on during the pandemic was to advise on and implement regulatory easement. Where the government were purchasing themselves for healthcare settings, the easement was that the Market Surveillance Authority could approve products without full conformity assessment where standards being used for that product were parallel and equivalent. There was no compromise of essential health and safety requirements. What was being looked for was ways of getting safe product to the frontline quicker.

When the pandemic hit, the suppliers were suddenly faced with massive expansion, new suppliers came in, existing suppliers had to ramp up their production, if you ramp up production, quality can fail. So, the regulatory effort that was necessary to avoid the unsafe PPE that began to flood into the market reaching the frontline was significant.

We need to make sure that people working in these highly dangerous situations are not being exposed to unnecessary risk. But at the same time, we have people wishing to supply, sometimes with good intent,

sometimes with bad intent, products that will not make those people safe. It represented an enormous stress test on the regulatory systems. We were not as well prepared as we could have been.

The Rt Hon Steve Barclay (Former Chief Secretary to HM Treasury)

In PPE alone, the Treasury's spending envelopes, that is the total amount of money it plans to spend over a set period of time, expanded 138-fold from 100 million to 13.8 billion. That is set by the Prime Minister, with the Chancellor.

The Treasury's role was one of overseeing public spending, but that was often delegated to AOs, (accounting officers) given the urgent pace at which decisions were required.

That decision reflected the imperative which was on saving lives but conditions will be attached to the envelope and one of the key mitigations that the Treasury put in place was to impose conditions alongside that increase. It wasn't practical for individual contracts to come to the Treasury, and that is why the Quad and Number 10 decided to allocate a spending envelope to speed up those, so that the bureaucracy didn't stop us securing those essential PPE contracts to save lives.

Value for money changes at a time of national crisis. The application of that principle changes because what constitutes value for money is then different. Was I comfortable that the government was paying eight times, or 14 times the pre-pandemic price? Of course I wasn't. But if the priority was to protect lives, then we needed to pay what the global market rate was at that time. That is why the principle of value for money would be applied but the test would be different to what it would have been before the pandemic.

It wouldn't be for me to assess the global market rate. We had a delegated envelope so that the accounting officer for the Department of Health could make that assessment. It is for the contracting parties, in this case the Department of Health, to make those assessments of the value for money, and other conditions such as checking whether the stock is suitable.

The Cabinet Office procurement policy which was issued in March expressly indicated a higher risk appetite, including instructions delegating payments in advance to accounting officers. It wouldn't be normal, outside of a crisis, for such advance payments to be paid for supplies, but the Cabinet Office guidance allowed that, because of the urgency with two weeks' of supply left, all efforts should be made. The concern was that other countries were going to out-compete us to secure those supplies.

The conditions were things like checking the quality of stock, because I was very concerned that we would procure stock that wasn't fit for purpose. If we paid for something at pace, do we have the ability to extract ourselves from that contract at a later point?

We needed to have clearer modelling data. One of the conditions I set specifically, I think, to this order was "A clear plan for managing excess stock." Throughout, we were pushing for better demand modelling. But to be fair to health colleagues, it was hard for them to provide that data at that stage because there was such uncertainty over the path of the virus, there was uncertainty over the levels of usage within the

NHS, because that data on inventory and burn rate was not available. And so the spending decisions were having to be taken without that information.

It's inevitable, that the contracting parties will have the information. I don't think it is inevitable that if the Department is aware of information some weeks before, that is communicated to me as Chief Secretary the night before the contract must be signed. I was frequently asking when did the Department first know of this? And why has the request come to me at a point where, if I don't agree, then the consequences is we lose critical supplies, which would put frontline services at risk. It was that late notification that was a source of frustration to me.

The Rt Hon Lord Feldman of Elstree (Former Adviser to the Department of Health and Social Care)

I had two very conscientious hardworking officials that were assigned to me. They kept a record of every single interaction that I had and they thought it was their job to then chase it up. I would have had no idea how to chase it up or indeed who to speak to. So they saw their job as: we've bought Lord Feldman in, he's trying to help, he's triaged all these opportunities, our job within the system is to make sure that they're being followed up.

I was endeavouring to credentialise the offer by saying this offer has been introduced by somebody that I know. I was endeavouring to be completely transparent where there was a political connection.

<u>SG Recruitment</u>

SG Recruitment was introduced to me by Lord Chadlington. David Sumner was the person running it. He was ex-military, ex-SAS, he had done a lot of business in Asia, was very, very connected to factories in East Asia and had what looked like an impressive team of people supporting him. So just from speaking to him on the phone, he sounded interesting and he passed that test of being deeply connected in the Far East.

I must admit I had a slight soft spot for someone who told me they served in the military and was ex-SAS and credentialised themselves in that way so I probably did think he sounded like a sort of decent guy when I spoke to him. I can remember him being articulate and impressive and also into the detail. The combination of all these things meant I thought it was worth Chis Hall having a look at.

Lord Chadlington's statement: non-executive director, a non-executive chairman of Sumner Group Holdings. The information I sent to Chris Hall included that Lord Chadlington was a Director. That had no effect on how I approached the offer. I can honestly say at the time it didn't really enter my consideration that Lord Chadlington held shares and the value of them could increase. His link is disclosed. It's transparent. You're in an emergency situation, you're always looking at a balance of risk. It's a factor to be considered. It's certainly a factor I would expect the transaction team to consider when it gets to the next stage of assessing the offer, but I didn't think that that should on its own preclude me passing the offer on if I thought it was credible.

I was not batting for them. I think Lord Chadlington is possibly operating under a bit of a misapprehension about what my role was. He may have viewed me passing the offer on initially as being very helpful, but it's no different to what I've done for anybody who I thought had a credible offer of help.

I passed them on because I spoke to Mr Sumner and he seemed like a credible knowledgeable person who might be able to help. It is of course the case in a wartime occasion, that frankly that mistakes would be made. He seemed like an interesting, credible person. I suspect that I didn't ask him how long the company had been trading. It's possible that I did but I can't honestly recall.

Helen Whately (MP for Faversham and Mid Kent and Former Minister of State for Care, DHSC)

5th April message to Matt Hancock

"Please can I have someone in the supplies team dedicate to overseeing PPE to social care? It is still all over the place. They've sent me contradictory info in recent days and cannot answer questions about flow. I am also told Clipper system looks NHS focused, and again, no one can tell me whether it will cope with 20,000 social care providers ordering stock, Day 1. There's only so long I can keep saying to the social care sector we're working on it without losing all credibility."

Minute from Health Ministerial Implementation Meeting 2 days later. There is no mention of the concerns raised with Matt Hancock 2 days earlier.

I cannot be sure what exactly I said in that meeting and whether I did or didn't articulate some of the challenges, and the minute doesn't reflect that, or whether it was the formality of the meeting meant that I just gave an update on the process that was meant to be happen. Unfortunately I don't have a more detailed record of it. I don't want to suggest that the minute is wrong but I don't have a more detailed record of what was or wasn't said

The initial understanding, advice I was given was very much that local authorities would be leading the response for social care, because they were the organisations that had the relationship with care providers. The Department's role for social care is much more to do with oversight. It was expected that social care providers would continue to get it from their wholesalers but the local authorities would be the point of contact. This is not to attribute blame; it's just to explain how the situation evolved. There came a point when I took a view in the centre that we need to do this differently.

I said I want to see those pandemic plans, because until I've seen one, how will I know that it's any good? I had received plans from 2 Local Authorities but they were in my view inadequate. I remember receiving the reassurances that the UK is very well prepared for the pandemic, and part of that is we have our national stock of PPE, and I wanted to be assured that wasn't just for the NHS; that was for social care as well, and I recall being told yes, it was for the NHS and social care, there is a national stock. I realised or felt that there weren't the set of local authority plans and the system wasn't ready at the frontline, I took a view, in discussion with the Health Secretary, we are going to need to do this from the centre.

What became clear, when I started hearing from care providers that they were not getting the PPE they needed, there was a problem with getting that PPE to them. One of the difficulties was getting things from the single national warehouse to around 25,000 different care providers.

I don't think there'd been any testing and working out in advance of how would we get PPE out to many thousands of care providers. So that had to be worked out in realtime, had those things been worked out in advance, we would have been in a better position albeit clearly one of the fundamental constraints was the supply. So you might have hit that bottleneck even if you had all the systems up and running.

We created what's the Infection Control Fund, which was a completely new method getting funding to care providers. The government had no established way of directly funding care providers, we've since legislated to enable that to happen should it be needed in the future but at the time it didn't exist. Over a billion pounds was distributed through that fund to the care sector. I did hear from the Sector that it made it a really big difference.

The portal distributed 1.8 billion PPE items to adult domiciliary care, so home care, and nearly 2.7 billion-items to residential care so in a sense of scale it was a huge operation. There were concerns about PPE being out of date, there was one particular exchange about some distribution of PPE stocks that had a label that said they were out of date, I remember going back and investigating and being told: no, those have sort of been re-tested and they are good to use.

We had very little data for social care staff because it's an unregistered profession. I know that I had an understanding that a significant proportion of the social care staff, would be staff from ethnic minority background but I wouldn't have accurate figures on who was working where. So quality was one of the concerns, as well as general supply. I thought if we had a Director General dedicated to social care then you would have somebody in the room in certain meetings. I also worked to get a new role of a chief nurse for social care to give another voice particularly for the social care workforce.

I don't remember at the time any advice or suggestion that different staff would need different sorts of PPE, whether that was by gender or ethnicity. I don't remember it being a factor. The concern I remember at the time was just how can we get PPE out of, you know, any sort of PPE to the frontline?

One of my concerns was that the national PPE supply, which was already struggling, was geared towards the NHS. I think there were greater challenges in getting it out to social care because of the nature of the social care sector, there were many thousands of different providers.

Why did there not seem to be a plan that was in place for social care? And I think this is one of the significant gaps. Although the view was that we were well prepared for a pandemic, in practice, it turned out we weren't, it didn't feel, certainly from my position, at least that we were very well prepared to support social care.

Sarah Collins (on behalf of the UK Health Security Agency, UKHSA)

PHE did not have the sort of remit to scale up the level of testing. NHS Test and Trace, was first set up in the middle of May, and took over responsibility for testing from PHE. That was initiated by DHSC.

There were various call to arms and engagement it was important for us to have faster ways of procuring. So, four email inboxes that were established, as a means of suppliers or referrers to put them forward. I asked for a review to be carried out to understand had there been any special preference to suppliers? The review concluded that these inboxes were a means of people getting in touch, it was a means of triaging requests, but it didn't give preferential treatment, it didn't circumvent the procurement process. It was a way of coordinating responses.

Every test has to go through validation. There would be a desktop analysis and then they would be put forward to the scientific teams in PHE and they would be evaluating the tests to see whether they were meeting the quality standards. They did that blind so they didn't know who had referred them. If they passed the validation, then it could be processed and a direct award could be established.

There were 50 suppliers who were identified as priority. They were identified in this category based on whether they had had a reference from an MP or a senior person in government, or someone who was a known person. It was not that they should be prioritised, it was more about who had referred them. I don't think they were categorised a priority because they are a contact of a minister or another high-ranking person. It's unfortunate that they were called priority, and one of our recommendations in this review was not to call them priority. We didn't find any evidence of them being given any special preferential treatment. We didn't feel that this particular inbox was prioritised more than another one.

We didn't find that particular suppliers were being handheld. I haven't seen any evidence of ministers pushing for specific supplies. In fact, I saw sometimes the opposite. There were couple often instances where suppliers were being quite proactive and wanting to get a foot in and we said to Lord Bethell can you deal with them so we can focus on our commercial work? So actually shielding the team, because it was very important that the team could get on with procuring the tests that had been validated.

A much higher percentage of contacts awarded came through the testing priority inbox. My focus was on establishing a new commercial function in UKHSA, where we have now got a front door which is managed in a very transparent manner, because industry does need an access point, but it's important that it's not influenced by people or that no one is being handheld, but that we are following the proper procedures. Calling the inbox priority was unhelpful.

Dr Beverley Jandziol (Former Commercial Specialist, Complex Transactions Team)

I became involved in the response on 18 March 2020 when I was asked to attend a meeting at DHSC. The crux of the conversation was that we were in dire straits. We had really limited capacity of PCR testing. The capacity across the whole of the NHS so PHE and Public Health England, was about 3,000 tests per day. Professor Bell had said we need to get to the hundreds of thousands, and we need to do it in days.

We needed new capacity. We needed additional machines. We needed additional personnel and additional supplies, and we could only do that in new laboratories because they've got a footprint in the

NHS lab that you couldn't just extend. The things we were procuring was not just the consumables but the laboratories, the testing sites and the logistics.

We bought a lot of tests, we tested them, they weren't validated, and we recouped most of the costs. We cancelled the contracts, and didn't take up the orders for those. At this point, we need one that's proven to work. That's when we went into the development of a test of our own with a consortia called Abingdon Health.

We were overwhelmed by offers and it wasn't sustainable. We were getting inundated with a lot of things that we didn't need, or they just weren't suitable. I think we had a good process, we had a lot of technical people so we became a lot more targeted. I do think the call to arms was a good idea because I don't think we were engaged enough with the life science industry. It gave us an opportunity to talk to suppliers who were working on things that were quite innovative and different.

If something had come into the process through contact who was a senior member of government or another politician, it wasn't marked fast track or priority. We would mark as to who it came from so that we could feed back. There was a time where we were getting chased to feedback and it was just so distracting. Most of the chasing wasn't coming from the referrer in our case; it was coming from the supplier. It was almost like the supplier who had been referred felt that they should be prioritised because they had a connection whereas a lot of the time it was just it was referred and the referrer wasn't chasing us as much as the supplier was. But either way it was just distracting.

Email from No 10 re buying 200 million tests

We had already bought 40 million, we were doing further validation and we were probably a week away from buying a more significant volume but I was told we needed to buy sooner. But we can't just spend over a billion pounds in a day. I'm the only civil servant on this email thread but we did push back and say we do need to buy these? I needed to do a business case and a ministerial submission. I did it all in one day with the support of my team, and we concluded negotiations on this over the weekend, which saved £700 million. We did deliver value, often pushing back at Number 10 and other senior individuals. This was a real challenge for our commercial team, including myself, around the pressure we were under, but we still would push back and do the right thing.

Oxford Nanopore had proposed to supply BGI branded PCR test kits. They had proposed to sell us 3 million at a price, with 100,000 on top gifted. I had concerns about this deal for a number of reasons. You buy some you get some free. It was known as a gift. We're not comfortable with gifts, but that was what the offer was. I had a number of problems with this. I think it's a really dismissive term to use when we were just trying to responsibly spend public money. But I was coming under a lot of pressure not to challenge the price, and I thought the price was inappropriate, even in the current market of significant supply and demand issues.

For reasons I can't go into today, there was a reason why we couldn't buy direct from BGI. But I felt the offer that Oxford Nanopore gave was unacceptable, and unjustifiable, and that's why I challenged it. But

I kept coming under pressure not to haggle. I recommended that the volume and price was reduced. It was escalated to Lord Bethell, and he said we wouldn't accept it at the price they were offering, so they reduced the price significantly. So, we reduced of volume of tests that were bought which was just as well, because I don't think we used them all. I think there was around 100,000 that expired, so had to be disposed of.

From the perspective of me and my team, we were still focused on value for money but we were challenged constantly. For us to just do our job, it felt like we had to have really thick skins and that just doesn't feel right, that for such an extended period we were constantly battling to do the right thing. Speed was definitely a number one priority, but you can still do that in a responsible way, but there was this view of we just have to spend. It doesn't matter, whatever it costs, this is what we have to do.

I can genuinely say we didn't want to delay something critical happening but trying to drive value for money. You have to do it when there was no competition, and there was no competition because we had to buy everything that we could use from everyone.