Week Three – Summary of Evidence

Witnesses

1. Chris Stirling (Former Programme Director of Covid Oxygen, Ventilation, Device and Clinical Consumable Response and Former Interim Director of Medical Technology, Department of Health and Social Care)
2. Matthew Style (Director General of Secondary Care and Integration, Department of Health and Social Care)
3. Professor Ramani Moonesinghe (National Clinical Director for Critical and Perioperative Care, NHS England)
4. Daniel Mortimer (Deputy Chief Executive of NHS Confederation)
5. Rosemary Gallagher MBE (Professional Lead for Infection Prevention and Control, Royal College of Nursing)
6. The Lord Paul Deighton KBE (Former Adviser on PPE to SoS, Department of Health and Social Care)
7. The Lord Agnew of Oulton DL (Former Cabinet Office Minister and HMRC Minister for Brexit Readiness)
8. The Lord Bethell (Former Minister for Technology, Innovation and Life Sciences)
9. The Rt Hon Matt Hancock (Former MP and Secretary of State for Health and Social Care)
10. Tim Losty OBE (Director of International Relations, TEO)
11. Dawn Matthias (Former Case Worker seconded to Department of Health and Social Care)

Chris Stirling (Former Programme Director of Covid Oxygen, Ventilation, Device and Clinical Consumable Response and Former Interim Director of Medical Technology, Department of Health and Social Care)

NHS had access to 6,000 to 8,000 ventilators so demand for ventilated beds and the associated kit was looking likely to significantly outstrip supply.

The process of a trust adopting a new make or model of a ventilator would take 12-18 months. We were often buying devices from specification. The nature of the market demand was such that this was often a cash-up-front make a decision within hours, otherwise someone else will buy the device.

25th March DHSC and NHSEI issued guidance asking them not to buy ventilators directly. Partly it was done to try and avoid trusts competing with each other and with us to procure ventilators. We accepted that we were going to be paying over the pre-pandemic price for all goods, and typically, we often paid up to double the pre-Covid price for items. The average price of the ventilator that I think we purchased through this initiative was £22,000 for an intensive care ventilator. The pre-pandemic norm for that was around £15,000. So, we did pay a Covid premium, but we didn't pay exorbitant or extortionate amounts of money to secure stock at any price.

A clinical due diligence team would check the devices. They would then be sent to a lab to assess performance.

I think it's very clear that at times in different part of the system, critical care was extremely challenged. What I'm not aware of is any time where there was critical care capacity, there's workforce, oxygen, medicines, beds, all set up but no ventilator. To the best often my knowledge that did not happen.

The use of anaesthetic machines in lieu of ventilators I think was relatively common at the time and clearly not optimal. I'm not the person to talk to the clinical appropriateness of that or not but that that was part of what was quite widespread, and at the time.

I do disagree with the core premise that there were localised shortages. If there were, I'm not aware of it, and that's not something that we've seen evidence previously. There has not been any reported shortage of oxygen or ventilation adversely impacting patient outcomes, it has, on occasion, been uncomfortably people close. The additional capacity built over the summer period of the pandemic placed significant extra pressure on oxygen infrastructure which became a primary constraint.

Existing medical device manufacturers tended to be slower and more risk averse in their willingness to try unusual and challenging things that need to be done, whereas suppliers from other industries are potentially more flexible. We did have discussions with many medical device manufacturers about scaling up their capacity. But my experience was that non-healthcare suppliers were faster and more agile at responding to our needs than existing medical suppliers.

Stockpiling is always going to be part of the answer. I think increasingly, if we're looking for a longer term and more sustainable answer, on or nearshore manufacturing opportunities, particularly in flexible production capabilities, potentially offers a more cost effective and sustainable route of achieving that. Stockpiles are very effective, but they are incredibly expensive. It is difficult to see any credible solution where a degree of stockpiling is not part of that.

Matthew Style (Director General of Secondary Care and Integration, Department of Health and Social Care)

DHSC and NHS England had a limited understanding about the number of ventilators available at that time. NHS England now carries out an annual survey of ventilator capacity. In March there were the tentative estimates of 6,000 to 8,000. By 9 April there were 9,600 ventilators available. By the 14th April, the department had procured a total of 10,993 mechanical and 19,338 non-invasive ventilators.

Overall, I think this particular procurement programme was less vulnerable to fraud than some others may have been, simply because it was easier to detect clearly fraudulent or clearly over-optimistic offers. If people were suggesting that they could suddenly supply three times the typical annual output of a manufacturing facility of a ventilator, it clearly didn't withstand scrutiny.

Professor Ramani Moonesinghe (National Clinical Director for Critical and Perioperative Care, NHS England)

NHS in England and I think across the UK has lower critical care capacity on a day-to-day basis than comparable countries. We went into the pandemic with approximately six beds per 100,000 population in England, and today, having increased our intensive care capacity we're at about seven. But many other countries are at nearer ten or 11.

A stocktake was undertaken towards the end of February which gave us the number of critical care beds and ventilators in the system which were around 7000. Around half of them were true critical care ventilators and the rest were second choice equipment. The reasonable worst case scenario data around 15th March 2020 indicated that we would need at least 30,000 intensive care ventilators, and possibly many tens of thousands more than that. So, starting with a baseline of 7,000, it was clear that we had a long way to go.

Because of the speed with which we were going to require machines to arrive into clinical practice, we had to moderate some of the clinical ambition about what these machines would be able to do otherwise we would set a specification that was unachievable, and patients would die as a result of not having machines available to them. We went into the pandemic really unprepared in terms of of the technology that we had available to us. We were really unprepared to be able to scale up critical care capacity and woefully unprepared for what we thought might be our reasonable worst-case scenario.

I heard a comment on earlier on that I was troubled by, which is "A bad ventilator is worse than no ventilator at all." Perhaps counter-intuitively, ventilators can cause further damage to the lungs. But that statement of a bad ventilator is worse than no ventilator at all was completely untrue in the context of the pandemic, because if the surge in demand had been as much as we had feared it would be, patients would have simply been left to die without that support. Thankfully the catastrophic surge in demand that we anticipated did not happen, and that was largely, if not entirely, down to the non-pharmaceutical interventions, the lockdowns. So that bought us some time.

I am not aware of any specific incident where a patient who needed a ventilator was not able to access one. However, I can't be sure that individual decisions weren't affected by the aspect of what was available. Even on a normal day, capacity constraints in the intensive care and possibly in other aspects of healthcare, do affect decision making. It is possible that anticipated pressure or real pressure may have changed subtly the way that clinicians thought about whether or not to send patients to intensive care or escalate their care.

I do not consider there was a robust system in place to ensure an adequate supply of key healthcare and supplies to the NHS. I think systems and processes were set up rapidly that were as effective as they could be in the circumstances, but we were not well prepared. Ideally, we shouldn't have had to have stood those systems up in haste at the end of February or beginning of March 2020. We would have had a plan that could have been executed earlier.

We could do more to have at least a bit of a buffer in terms of stockpiling and supply. The most obvious way to do that the is actually just to expand critical care capacity. If we increase that, we would use it, because we would send more patients to critical care for their operations and we would then have a bigger buffer in the event of a pandemic surge or another emergency.

The outcome of procurement of equipment and supplies wasn't sufficient to enable healthcare workers to meet the same standards of care to patients. Patients were treated with equipment or medicines which were either not designed for that purpose or didn't provide best practice and were treated by staff who were not necessarily fully trained to do so.

Daniel Mortimer (Deputy Chief Executive of NHS Confederation)

The Confederation is a membership organisation, it represents the whole range of organisations that commission and deliver healthcare in England, Wales and Northern Ireland. One of our particular roles in the pandemic, was to collect insights and to reinforce them with the government and various arm's-length body organisations.

The availability and suitability of PPE was "the dominant theme of the feedback during the first phase of the pandemic. Every part of the health service as well as our colleagues in social care were reporting a lack of availability of PPE. There was a perception by our members, particularly outside of hospitals, that there were availability issues everywhere, but they were particularly challenged in GP surgeries, community settings, mental health services.

There was a particular concern around the availability of equipment that could fit different types of faces, whether that was because of gender differences, or because of ethnic minority or religious observance issues. There was some disagreement about guidance, in particular, around what were and weren't aerosol-generating procedures. That drove concern and anxiety, but it also drove demand for masks with respirators, FFP3 masks, irrespective of the guidance.

There was a profound anxiety. There was a lack of confidence in both the supply but also the guidance. Had it not been for accessing PPE from schools and other voluntary organisations and from our own contacts with suppliers, we would have run out a long time ago. The national supply chain has been inadequate. The PPE emergency line has been unreliable and failed to deliver what was expected of it and we still have no confidence in it. People believed that the guidance wasn't fit for purpose, and they were having to set higher standards for themselves and their colleagues.

There was a feeling that guidance and the reframing of guidance, which happened a number of times, was a function of what was available. There was a belief that there was a lack of transparency.

Rosemary Gallagher MBE (Professional Lead for Infection Prevention and Control, Royal College of Nursing)

The call centre and online platform received more than 3,500 queries just relating to PPE. That was an unprecedented number of enquiries. 1,300 of those reported lack of access and 700 related to general shortage or a lack of specific items.

We had many concerns from members around material degrading. There were distressing incidents of respiratory irritation where they were inhaling the fibres from these degraded masks. A significant

number of members at that time reporting being asked to reuse what had been designated as single-use PPE. To be asked to re-use single-use PPE was a significant cause of concern to them. 34% of respondents felt pressure to care for individuals with possible or confirmed Covid-19 without adequate protection, and 56% of respondents from ethnic minorities felt pressure to work without the correct PPE.

There was a lack of clinical engagement in procurement decisions. The clinical engagement is being done after the purchasing decisions have already been made. Its too late once decisions have already been made. Specialist procurement nurses are registered nurses that have worked in clinical environments that have moved into support procurement teams in NHS trusts to make decisions about the right products for use in clinical practice. These nurses are not only experts in how products are used, but they also are aware of how clinical practice is changing and adapting over time, and there is a risk that products might not keep up with clinical practice. Specialist procurement nurses would understand in depth, the human aspects of how products are used and what makes it a good product or not. They would also be very knowledgeable on, for example, the implications for buying a poor-quality product.

Wastage is a real issue within the NHS, and something that procurement nurses are very mindful of. To have these items of PPE delivered to their trust that were clearly not fit for purpose and see the huge amount of waste that occurred as a result, was really distressing to nurses because they knew that if they had been involved at an earlier stage in assessing products, that have been avoided.

I reminded NHS England there were a number of experienced RCN members who would support the Evaluation of PPE procurement either by the DMC (Decision Making Committee) or as part of various groups looking into different aspects of current and future procurement of PPE. I am unable to locate any response. One of the key lessons that should be learned is the involvement of the frontline perspective in the procurement process.

The Lord Paul Deighton KBE (Former Adviser on PPE to Secretary of State, Department of Health and Social Care)

April 2020 became advisor on PPE to Secretary of State of DHSC. Initially when I was appointed, it was with the specific objective of getting UK manufacture of PPE going and it subsequently was expanded to include the broader project. It was very clear to me that anything that we'd had in place before that completely broken down. It was clearly not sufficient to cope with the scale of the crisis.

The whole world was trying to deal with the same problem of that enormous increase in demand and was competing ferociously for the very finite amounts of supply available at that time. My mission initially was to get some real traction with UK manufacturing. To get things done it was essential 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. I gave the team a very clear mandate, which was to find the manufacturers in each of the categories which could produce the volumes we required quickly, to the quality we needed, and at a competitive price.

The principal way the manufacturers needed financial assistance was the assurance of the contract. The nature of product approvals was you do one thing, then you go to the next thing. And in certain cases there was no reason for one to follow on from the other. You could do two at the same time. The whole point about safety is that it's a slow and highly deliberate process. We still needed deliberate but we didn't need slow. So, we could parallel up the normal processes that they would go through, and then you have to deal with capacity issues and constraints on testing houses.

With foresight and planning you probably would have pressed that button in February. I think, even in the crisis we were in, what I was able to start at the end of April, I see no reason why that couldn't have started at the end of March. The problem was a lack of preparation.

The Lord Agnew of Oulton DL (Former Cabinet Office Minister and HMRC Minister for Brexit Readiness)

One of the most useful things I did was to get Gareth Rhys Williams to push a lot of his commercial people into the Health Department so they could get a grip. But the Health Department did not welcome my involvement, and I was closed out of the process. There was no strategy or guidance, it was firefighting. We always knew there was this problem with the Health Department; there wasn't strategic thinking going on.

I decided I could be most useful with the ventilators, because that was outside the Health Department, it was a Cabinet Office initiative. They had no clue what they held in inventory at any level or at least it took a huge effort to get access to this. I tried for three months to get oxygen capacity and consumption data for all hospitals as this was a key determinant in how many ventilators a hospital could support. I asked for a simple spreadsheet showing oxygen delivery capacity per hospital. I never got it. I must have asked 20 times. Even if we'd delivered hundreds of ventilators it wouldn't have been any good if they didn't have the supply of oxygen to hook them up. The reason I gave up in the end is because ventilators subsided as one of the critical solutions, so I didn't persevere. It was an example of the incompetence.

It was the fraud that really got to me. One of my roles was minister for spend controls. When I arrived the first submission I got was "we'd like to shut down spend controls." I was also Minister for Efficiency, so I wasn't going to let that happen. It's standard procedure in government to hit a new minister with something they'd like to slip past him or her quickly before they've found their feet in their new role. But I wasn't having that, so I pushed back and we kept the spend controls in place.

The value of the Department of Health exemption was a shocking 70 billion a year of spend that should have come through this scrutiny but didn't have to. One of my submissions was for £11 billion which I finally got reduced to about 600 million. It gives you an idea of the sort of sloppy thinking going on around government. it's this is a sort of lazy sloppy talk that you get "we're saving the world, we're going to spend the money as we like." They were so panicked that they just went rushing off to get whatever they could. There was no coordination that I could see. They could just roll me over because they could pull the "it's a national emergency card." I even got them to write a formal letter of direction which at least forces accountability and responsibility back on the people trying to spend the money in this extremely undisciplined way. The country has to get angry about this sort of incompetence.

I'd lost confidence in their ability to strike reasonable deals. Government was already addicted to consultants. I was appalled at the costs of consultants. I tried to reduce this with Deloitte's and the call centre they established in the Department of Health for Baroness Harding. They had over 15,000 employed with an FTE utilisation rate of less than 5%. The idea that you needed a call centre of 15,000 people with a utilisation rate of 5% is beyond a joke. That's why I tried to get the 15,000 reduced. I think we got it down to about 11,000 briefly, but as soon as my back was turned it went back up again.

The only role I played in the High Priority Lane was to talk to potential suppliers who contacted me or Michael Gove to try to establish whether they were credible. If I thought they were, I would refer them to the government commercial team. I did not have a role in the establishment, operation or supervision of the HPL other than referring credible sounding people to the CS commercial team. It was absolutely vital that we had some order. I'm frankly very confused at why people are in such a state about this. We had no alternative. I'm absolutely unapologetic. Yes, probably some crooks came through the VIP Lane. I'm sure we got stuff wrong but I really do think this obsession with the High Priority Lane is misconceived given the circumstances that we were faced with.

If one sees the colossal amount spent on PPE, much of which is now been burnt, one can hardly regard it as a success. Disposal of surplus PPE was one of the most upsetting parts of the whole procurement journey. There was vast over-ordering. 6.9 billion-items of surplus PPE. That was a figure that reduced down to 4.9 billion by 2023, but it continued to cost £120 million a year to store excess PPE and £3.8 billion worth of stock expired before it could be used. If there had been inventory management in the hospitals, this need never have happened. Why on earth one of the most allegedly advanced economies in the world did not have that embedded into its health system is beyond my comprehension.

Email from Lord Agnew: *"We're going to have to handle Dyson carefully. I accept that contractually we can walk away, as he hasn't delivered by the due date. I suspect we'll have to buy a few machines, get them into hospitals so that he can then market them internationally being able to used in UK hospitals."*

I presumed he had produced something that worked. You think he's been given some favouritism here, maybe we have, but the rate of which he was pushing his own development gave me that reassurance. I don't think it was a mistake to keep Dyson in play until we got to the point at which we knew his machines couldn't work. It was my job to ring Dyson and let him know. That was the hardest phone call I have ever had to make in my professional life. This is a man who is not used to failing.

My own view is that lessons have not been learned. It's always revert back to the same, plodding mediocrity.

The problems that arose were in how the prioritisation took place with too great an emphasis placed on who made the referral as opposed to the nature and promise of the lead. I want to reassure you there was no plan to enrich a few of our mates. That's such bollocks. We were in the most terrible position, and they were the most incredible people who came forward. There was no doubt one or two crooks and cranks but they were largely credible.

The Lord Bethell (Former Minister for Technology, Innovation and Life Sciences)

At the very, very early stage, the NHS procurement system was under huge strain and parts of it, including SCCL, completely fell over.

The UK had one of the worst starting points in Europe. we had, in PHE, fabulous scientists who were extremely good at the analysis of viruses but had no ambition or remit for putting together the kind of population health diagnostics that other countries had. That was a very weak platform to build our response on.

I think that public health generally has been underestimated in terms of its value to the country, both in terms of supporting the underlying health of our workforce and of our people, in providing resilience at times of crisis and also in terms of reducing pressure on the NHS. There is a fundamental misallocation of resources in our health and care system. 3% of our budget roughly spent on public health, and that is much lower than in other organisations. People in public health have got a low status compared to those who run acute hospitals. We need to pivot to prevention in a massive way and this is a glaring example of that.

8th April 2020 the DHSC issued a press release launching a portal for companies to offer their services to bolster the UK's diagnostics industry. There was an overwhelming amount of interest in it, and we struggled to manage the huge amount of interest. We set up a call centre for people to handle it and a webform for people to fill in, but the response was not as well organised as I would have liked them to have been. We were drowning in helpful suggestions. I was surprised that a relatively straightforward task of canvassing a large amount of interest amongst UK industry and then processing those expressions of interest seemed to be a bit of a struggle for the system to work through. Triage of offers is part of the procurement process. In fact, that kind of transparency, particularly at a moment of heightened public concern, is important.

Suppliers being designated as VIP or priority is not something I had a hand in. I don't recognise a list of VIP suppliers. There was a list supplied by the industry bodies of people who had experience in that area and they were naturally prioritised.

Where emails came from a supplier with an established reputation in diagnostics or related to products or services of which there was an acute shortage, the email could be tagged by the triage team as VIP, fast track, or priority. "We were invited to mark the email as fast track in order that it could be tagged as such and to help officials to provide progress reports. This is quite different to the VIP Lane. It is a criteria-based prioritisation system.

Provenance does count for something, but not the only thing. By provenance I mean the identity of both the referrer and the ultimate source. A Cabinet Minister vouches or for something, then their mandate does count for something, and in the algorithm there's a mixture of the two. I was trying to make sure that people who had good ideas and good recommendations got through, and the people who were time waster or fraudsters got turned away.

The British Government had not bought diagnostics in a serious way in this. So major diagnostic companies did not regard Britain as a key customer. We needed to put a buy signal into the market. For credible diagnostic companies, we had to reassure them that we were going to be a reliable, pay on time, customer. So yes, feedback to them was very important. To the time wasters, feedback to say, "Could you please stop wasting our time and stop writing articles in the daily mail and stop phoning the Prime Minister" was also important.

Capitalism saved us. If it hadn't been for the profit motive, we wouldn't have had a vaccine, we wouldn't have been able to stand up extra hospitals, and we wouldn't have had PPE.

Randox:

On 30th March Randox was awarded a contract by the DHSC to supply around 2.7 million tests over a 12 week period. MP Owen Paterson was a paid consultant for Randox. It was published in his register of interest, so it wasn't a secret. I gave authorisation for civil servants to start contractual negotiations with Randox on 24th March 2020. Randox is the standout candidate for working in the diagnostic area. If someone has put something in their register of interest and are utterly transparent about it, then it doesn't qualify as a conflict of interest.

I think that the attention around Randox has been highly politically motivated. I think it's a great shame that a British company has been demonised in that fashion. Other British companies will take that lesson and will be extremely reluctant to step up to the challenge in the future, and I think it's a great shame what's happened to a good company.

Resilience is not a mystery. We know how to do it. It's all been extremely well explained in government policy. But we've chosen not to go down that route and I think that that is a mistake. There had been a failure to acknowledge the lessons from SARS. I think that we have just underestimated the societal lack of resilience we have in terms of volunteers, British industry, the use of data, and we need to think again, and take lessons from countries like Finland, that have put resilience at the to be of the agenda rather than at the bottom.

The Rt Hon Matt Hancock (Former MP and Secretary of State for Health and Social Care)

On coming into post as Health Minister, I was advised that the UK was a world leader in preparations for a pandemic. I had no reason to doubt what I was told. There wasn't a plan for replenishing the stockpile. I first ordered the opening of this stockpile and the ordering of more PPE in January 2020. The purchasing of PPE was essentially decentralised with the exception of SCCL, which only existed to supply the 250 main hospitals, not the tens of thousands of other areas that came to need extra PPE.

PHE's audit of PPE concluded the paperwork is all over the place. There's no clear record of what's in the stockpile, and some kit is past its 'best before' date. "I've instructed officials to work out what we need fast and buy in huge quantities. I wasn't given any explanation as to why some kit was past its best before date. It's obvious that you need to keep a decent record of everything that you put into a stockpile. The bigger problem was that it wasn't pickable.

Public Health England had in stock 6.84 million out of date respirators that were being tested for shelf life extension. I instructed SCCL to increase its buying activities. The purpose of SCCL was to have an efficient system of delivery of supplies to hospitals. Efficient in normal times, means carrying as little stock as possible. But in a crisis, that leads to lower resilience.

The commendable drive in normal circumstances for value for money and for efficiency meant that when the pressure of a radical increase in demand met with a radical constriction of global supply, because everybody else's demand was going up too, the idea of having this just in time delivery system collapsed, and with it, SCCL The preparations that had been put in place were not adequate to the task. SCCL collapsed. By that I mean it was no longer able to manage the supply of PPE to the NHS

Testing capacity, was very well stood up at a scientific level very early, but then PHE had failed adequately to expand testing, and had failed adequately to engage with the private sector, and as a result of that, I had taken responsibility off them on the evening of the 17th March,.

21st and 22nd March, DHSC officials developed the Parallel Supply Chain, taking procurement out of the hands of SCCL and bringing it in-house to DHSC. I don't who made the decision or why that was done rather than adding support to the SCCL. I do think it was the right thing to do. 23rd March I formally approved a request from the NHS for military aid for PPE distribution. One of the problems that the warehouse, where the PIPP stockpile was stored, was in deep storage in the North West and not designed for rapid access. They need to be structured so they can be picked, preferably automatically, and using machines. There needs to a data system so that we know exactly what's in it, when its sell by date is. There needs to regular audits of that stockpile.

The Call to Arms for PPE. I don't recall whose idea it was. We were radically short of PPE. The PPE was about to run out at a national level, and there were local shortages of supplies of PPE that we were aware of and a lack of PPE has the potential to lead to death, I was worried amongst health and social care workers. It obviously led to more pressure because we were inundated with offers. The result of it was more PPE. We came within hours of running out as a country, even if it was only a marginal improvement in the supply of PPE, I would take it because my total focus was on saving lives. Nobody has testified that the PPE call to arms led to anything other than more PPE, so I stand by it.

In some cases, we paid expensive prices for it but I think that was worth it to save lives. In the end on PPE, we over-succeeded. We procured more than was needed. We knew when we went into this that some of the offers would be inappropriate or indeed fraudulent. But the normal PPE supply chain was totally inadequate to the task that was needed, these were life and death consequences of whether we got more PPE or less.

All of this needs to be done whilst removing the standard rules that slow down this process enormously, which are necessary and proper in normal times, but are not adequate in these times. The integrity of civil servants who gave their all in that time has been impugned since, and I fear that it will be harder to procure PPE in the future because people will look at the treatment that some of the people involved have received, including some of the sort of undertones of some of the questioning.

Every country will have had some kind of system for dealing with this problem. Ignores that no other country did it this way, despite the fact that they were all facing the same set of circumstances. I have been subject to enormous amounts of conspiracy theories about what went on here. People are alive who would otherwise be dead.

The oversupply was rather larger than I anticipated, but it is better to err on the side of more supply, because if you err on the side of less, we run out and we got very close to that.

We must recognise that the proportion of people who work in the NHS and in social care who are from ethnic minority backgrounds is much higher than in the population as a whole. So the future PPE stockpile must, must be appropriate for the workforce.

Tim Losty OBE (Director of International Relations, TEO)

Director of International Relations in China from 2014. I was evacuated in Feb in 2020 on a temp basis but maintained role as Director. I would not normally have had any role in procurement in any of the roles I had

There were various measures that the Department of Health, the Department of Finance and the company itself had in place to prevent fraud such as due diligence checks and the decision to split the order into two batches to mitigate any risk.

Dawn Matthias (Former Case Worker seconded to Department of Health and Social Care)

I've had experience of quite robust assertive suppliers in the past, the big difference in this instance was the extreme persistence and the volume of that extreme persistence.

Email: *"I am assigned to what has been termed VIP suppliers who are the ones who believe they are too important to complete a survey, as they have a link to a minister".*

The nature of the suppliers that were being triaged through the HPL team were senior contacts within the supply chain who wouldn't be, I guess, either adverse to, or used to being advised to complete a form. It would be inconceivable, I think, for them to be asked to do that.

12th May 2020 email: *"I would love for an FOI to be put in after all this to see the percentage of orders. So PPE raised within the VVIP suppliers/those with party connections. I suspect it would be on the high side based on what I've seen going on."*

This was my curiosity in terms of how fruitful was the work that HPL team were doing, in terms of return on effort. It was 12, 15 hours a day, seven days a week, lots of triaging, lots of processing, lots of difficult stakeholder conversations. It was curiosity in terms of the percentage of cases we've triaged and the conversion rate.