Week Four – Summary of Evidence

Witnesses

1. Jeane Freeman OBE (Former Cabinet Secretary for Health and Sport, Scottish Government)
2. Caroline Lamb (Chief Executive of NHS Scotland and Director General of Health and Social Care)
3. Gordon Beattie (Director of National Procurement, NHS National Services Scotland)
4. Paul Cackette CBE (Former Deputy Director in Organisational Readiness, Director of PPE and Director of Outbreak Management, Scottish Government)
5. Chris Young (Former Co-Director of Finance, Department of Health and Social Care)
6. Andrew Slade (Former Director General, Economy, Skills and Natural Resources, Welsh Government)
7. Jonathan Irvine (Director of Procurement Services, NHS Wales Shared Services Partnership)
8. Richard Davis (Senior Welsh Government representative of the Critical Equipment Requirement Engineering Team)
9. Karen Bailey (Chief Executive, Business Services Organisations, Procurement and Logistics Service)
10. Chris Matthews (Deputy Secretary Resource and Corporate Management Group, Department of Health Northern Ireland)
11. Conor Murphy MLA (Former Minister of Finance, Northern Ireland)
12. Major General Phillip Prosser (Ministry of Defence, former deployee to NHS England PPE Team)
13. David Williams (Former Director General and Second Permanent Secretary, Department of Health and Social Care).

Jeane Freeman (Former Cabinet Secretary for Health and Sport, Scottish Government)

I was ultimately politically responsible for ensuring that the health workforce in Scotland had access to appropriate PPE during the Pandemic. NSS acted as the single procurement arm for the whole of the NHS in Scotland. That covered all items of procurement that would be needed in a health setting. I was politically responsible for it.

Scotland did not have a fast-track system for new suppliers. Absolutely not. All were passed straight to NSS who, in collaboration with their colleagues in Scottish Enterprise and Scottish development, had a proper triaging process that would apply due diligence to all those offers. We did not have a VIP Lane and we did not need one. This is the counterpoint to the evidence of the likes of Matt Hanock who repeatedly justified the VIP Lane by asserting that it was necessary because of the pressures of the pandemic. Other countries were in exactly the same position but did not resort to triage methods that would favour their mates with multi million-pound contracts.

Pre pandemic primary care and adult social care had secured its own PPE. In the circumstance of a global market for PPE that is highly competitive it was very difficult for them to secure their orders, and they needed more in addition. I took the decision that we would take over that supply through NSS. It was a logistical challenge to set that up at pace. For the next pandemic, I think we are much better placed in

understanding, for example, the importance of wrapping our arms around from the outset all of health and social care, regardless of the model that may exist.

I do not entirely agree with Dr Macaskill that we considered the social care sector as secondary within the NHS. As soon as he and others raised those problems that individual care homes had in securing both the quantity and the type of PPE that they needed, we acted quickly to ensure that we could be the supplier of that PPE. I think NSS responded very quickly and very collegiately to trying to work out, with Dr Macaskill and others, what would be the best route for individual care homes to provide their volume demand information to NSS.

Speaks to the disconnect between those in charge and those on the ground. What for a politician may seem very quick could for those on the frontline feel like a lifetime. The fear of going into a shift not knowing whether you would have the correct PPE. The fact that those in charge were working very hard to resolve the situation may come as small comfort when you know that you are literally risking your own life by going to work.

Any PPE secured through the UK-wide procurement approach would be proportionately distributed across the four nations using the standard formula for distribution. If you are uncertain about what your share is, you can't plan with confidence. In my view the devolved approach is better because it allowed us to create a significant domestic supply chain. Just over 80% was domestically procured.

The suppliers of PPE in England had been instructed to prioritise English NHS settings over Scotland, even where suppliers were contractually committed to Scotland. This was raised in a meeting with Matt Hancock. I did not expect Mr Hancock to say, "Yes, you're absolutely right, and that's shocking and I'll make sure it doesn't happen." But I was laying a marker down that said, "We are aware of this, and I now expect you to do something about it, without you actually admitting that it exists."

That is just absolutely remarkable and yet this only came out as a result of our questioning.

Caroline Lamb (Chief Executive of NHS Scotland and Director General of Health and Social Care)

There was limited opportunity to rotate the PPE items within the stockpile, resulting in some stock going out of date and having to be revalidated before use. We were comfortable with the process that was in place to revalidate the stock, and we were very clear that we were not going to accept any risk in using stock that was not revalidated.

In Scotland, we had recognised that we needed to have a much more robust approach to modelling, including understanding what levels of stocks were held not just centrally but locally within boards. At a UK level that was more challenging. We didn't really have visibility of what the UK pipeline looked like, when deliveries would be expected etc. It was only really after about February 2021 and probably in line with that protocol finally being agreed and signed, that there was clear agreement that we would share that visibility of approach across all four nations.

That it took that length of time was one of the reasons why it was helpful for us that NSS was able to establish a centre of excellence for procurement and that they had well-established supply routes. I don't think there was a material impact on the supply of PPE to Scotland as a result of it taking so long to agree those data sharing arrangements, but perhaps things could have been improved if that had been in place earlier.

The FCO advised overseas networks not to support new procurement. I don't think that was appropriate. The overseas networks absolutely are there to provide support to the devolved nations within the UK. It wasn't for England to decide unilaterally that those mechanisms should not be available to Scotland.

Our approach was, as far as possible, to try and procure ventilators that were of the same make that we were already using in Scotland, because we didn't want to clinicians to be already under extreme stress to also need to deal with many different types of equipment. We wanted , as far as possible, to be able to supply them with equipment with which they were familiar.

Contrast this with the approach in England which seems to not only ignore the importance of familiarity with complex equipment like ventilators but to try to get inventors to create completely new ventilators from scratch which no one would have any familiarity with.

Having a single pandemic and distribution plan didn't serve us well, and that's the reason why we used NSS so intensively in Scotland to procure for us, because we were not getting the PPE we needed through that single UK approach. Potentially, that could work differently in the future, but that would need to be a collaboration of equal partners that brought all the devolved territories to the table.

Gordon Beattie (Director of National Procurement, NHS National Services Scotland)

We were managing Scotland's share of the UK stockpile. There was a replenishment order with a French company. We were due to receive 643,000 items but France cancelled the order. I don't think we could have envisaged that happening. That ultimately led to the failure of that strategy. In January and February I didn't have concerns about the ability to replenish the stockpile because it wasn't until European countries started shutting their borders that it became evident there was something happening that we'd never experienced before in anybody's lifetime.

We knew what we had stock nationally because we had good national stock systems but the systems can't tell you how much you've got in each hospital. So we had to rely on manual stock counts by staff. We now have a system that tells us how much stock we have at each hospital.

Paul Cackette CBE (Former Deputy Director in Organisational Readiness, Director of PPE and Director of Outbreak Management, Scottish Government)

Created a newly formed Directorate of PPE to respond to concerns about the supply issues.

The delivery of PPE to public and private nursing and care homes in Scotland was the single biggest and most difficult challenge. NSS Scotland were used to providing PPE into primary and secondary healthcare settings and I was reasonably confident they could scale up to do that for the pandemic. But to deliver to care homes and nursing homes was different from what they had experience of doing. It was the transition into new arrangements and the risks of setting up new systems, in the most acute of times, and the risks that that brings.

We were not prepared to face the scale and enormity of the challenges and to a degree we never could be. A lack of preparedness for the next pandemic of the nature of the last would be unforgivable.

Chris Young (Former Co-Director of Finance, Department of Health and Social Care)

Prior to the pandemic the Department was not making significant purchasing activities to warrant the need for an accounting officer assessment. They were few and far between leading up to the pandemic.

Our key requirements are regularity, propriety, value for money and feasibility/deliverability. We may well have to take a higher risk appetite when it came to accepting that certain stock may not end up being what we thought it was. We would have to take a higher risk appetite when it came to value for money.

It was very, very difficult to assess with any degree of confidence that the deal that was presented to you would arrive as expected. It was not possible to eliminate risk. It wasn't practical or possible. If substandard products did ultimately arrive, there would be a clinical check on arrival. It would never be put into the distribution of the NHS. And we would look at the commercial remedies so there was some recourse for where deals didn't necessarily come through as we would expect.

The accounting officer assessment came at the end of an eight-stage process. The team at stage seven brought together everything and provided a summary to the accounting officer that then enabled them to apply the contextual knowledge they had from the demand data, and the risk appetite, and form a view on the deal. We would not scrutinise the pack if the checklist suggested that assurance had been done. The checklist provided the accounting officer with the assurance that everything that he or she would have expected in the previous seven stages had been done.

The pack would include Supplier quotation including, a comparison to the average price benchmark and an explanation of why the offer was reasonable or better to proceed in the circumstances. That was an important point that I would have looked at in a little more detail. Value for money was another area where we had to take heightened risk, because we had no leverage when it came to price. What we did try to do is safeguard the public purse as best as possible by having a rolling seven-day average as a benchmark on price, and that would be something that the accounting officer would pay attention to.

"The relationship between a referrer and a financial backer of the supplier had no effect on my decision to approve contracts, which had been through the High Priority Lane."

I'd absolutely agree with that approach. It didn't matter to me personally where a deal had been referred from or to. What mattered to me is that the appropriate assurances that came within the first seven

stages had been undertaken, and the deal was being recommended on the basis of it being a sound deal. The level of profits of the supplier and distribution of profits had no effect. It was clear that huge profits would be made. That was unavoidable.

Andrew Slade (Former Director General, Economy, Skills and Natural Resources, Welsh Government)

Welsh Government made a number of attempts to stimulate domestic manufacture to create a new Welsh supply chain of PPE. Welsh manufacture of PPE won't be a solution in and of itself, and it's very unlikely that UK manufacturing is going to be the cheapest source compared through what is available in international markets. You have to be realistic about that.

Royal College of Nursing carried out a survey among nurses in Wales. It found as follows:

- Only 46% of respondents said they had sufficient supplies of fluid resistant masks.
- Only 52% had sufficient supplies of eye protection.
- Only 57% had sufficient supplies of gowns.
- Only 63% had sufficient supplies of FFP3 masks.

You can have enough PPE stocks in circulation at the national level and yet there can be problems at the local level, in terms of distribution and supply.

I don't think care homes were overlooked. There were conversations going on back in February about how best to get supplies into the care sector and then those manifested themselves in the decisions taken in March to roll into the work of the Shared Services Partnership, the provision of supply into the care sector.

Jonathan Irvine (Director of Procurement Services, NHS Wales Shared Services Partnership)

NWSSP was responsible for managing and storing the PIPP stockpile. We were aware that items had expired by early 2020. That prompted action to carry out further testing of those items. Three tests undertaken. The first two tests extended the date life on two occasions, on each of those two occasions the products were over-labelled with the new, approved expiry date. On the third occasion, there simply wasn't time to do the labelling again. So NWSSP put together frequently asked questions or FAQ guidance form that went into the box with the FFP3 masks to explain to staff, when they opened it, would see the expiry date didn't match, in an attempt to allay some of the anticipated concerns that would be raised by staff.

We found that we had more than enough PPE in the equipment stores but the local authorities weren't always aware of what was there. I have no reason to dispute the lived experience of people in care homes, carers, staff. I think the more important issue here is to understand what the responsibilities of my organisation are and where they started and where they ended.

That national position, in our warehouses we did not run out of stock on the shelf. We continued to supply day in and daily to the NHS, to social care and to primary care, to the point of delivery in those particular areas. What happened to the product after it was delivered and how it was managed and distributed onwards is the responsibility of other organisations.

Richard Davis (Senior Welsh Government representative of the Critical Equipment Requirement Engineering Team)

My role was the lead government official within the Critical Equipment Requirement Engineering Team (CERET). My measure of success is the fact that we never ran out of vital, critical equipment.

CERET made a risk-based decision to commit to purchasing 10,000 component parts for ventilators before the exact forecast demand was known, in view of global demand. Subsequently, we revised that position and reached the conclusion that we only needed 2,000 of those components. Several steps were explored to mitigate the financial loss. Ultimately the cost of those parts was written off to the tune of £565,000. Would I make the same decision again? Knowing what I know now? Clearly not. But would I make the same decision knowing what I knew then? Yes, I would.

Karen Bailey (Chief Executive, Business Services Organisations, Procurement and Logistics Service)

BSO PaLS is a Centres of Procurement Expertise. They work with all the health and social care organisations in terms of sourcing, procurement, warehousing and logistics for the various health and social care organisations that we support.

EMM is this electronic materials management system that works at ward level and at theatre level in the trusts and is an inventory management system whereby 24 days of stock is handled and stored at the ward level. When the usage gets to a point of 12 days there is an automatic trigger to our warehouse management system in our central distribution points to replenish the stock at the ward and the theatre level.

During the pandemic the EMM system was superseded by the push arrangements. That was through central hub arrangement at the Trust levels. Trust hubs would not have allowed acute wards just to automatically replenish at that point. We have now reverted back to the EMM system.

We realised that supply chain was struggling from an early point we would have got a lot of our masks and cleaning products through Supply Chain, so that was going to be an area of concern for us. We'd had some experiences with the NHS England thing where the mutual aid just wasn't able to be confirmed. It really was that lack of confidence that if we were depending on that, we wouldn't be in a good strong position locally.

We didn't release the PIPP stockpile all at once at the start of the pandemic. It was used as a bridge to supplement any gaps or where we were getting particularly low. It was used as a kind of reserve. That worked very well for us.

In Spring 2020 it became clear that NHSE was not going to be able to fulfil our procurement needs so NI would have to do much more direct procurement. The Department set up a PPE mailbox directly into PaLS itself. There was a real deluge of offers so a triage process was set up. It logged initial contacts, and then there was a more rigorous follow-up process, getting further information. We got about 2,000 approaches from different companies. Having gone through the triage process, we identified about 45 really useful leads.

There was no equivalent High Priority Lane or VIP Lane in NI. All offers of help went through that triage process. Our logs would demonstrate that it was quite a rigorous process that applied equally to everyone. Offers were dealt with on a sequential basis except for offers of FFP3 which were prioritised and dealt with via separate stream.

There was a rapid review of PPE in April 2020, commissioned by the Minister of Health. They took samples and put them through quality and user acceptance. That was influenced by the experience we'd had with the NHS Wales contract where we had sourced a face mask that met all the technical standards, but the user preference was not met and staff had concerns that it didn't create as tight a seal as to what they were used to. It meant that products had had a very rigorous assessment prior to any orders being placed.

Chris Matthews (Deputy Secretary Resource and Corporate Management Group, Department of Health Northern Ireland)

PaLS is a unit within BSO and it's the procurements and logistics service for Northern Ireland for the Northern Ireland health service.

The rapid review was commissioned on 15 April by the Minister for Health. It was commissioned to get a strategic sense of what was happening and what kind of things we ought to do as a system to get better control over the PPE situation.

In the early stages, even though there were sufficient supplies of PPE, because of the initial pool system, some of the PPE was in the wrong bits of the system and then had to be moved to other areas. I think it was a distribution logistics problem rather than a supply problem.

Conor Murphy MLA (Former Minister of Finance, Northern Ireland)

I had responsibility for the development of the procurement policy and legislation. I chaired the Procurement Board.

The PPE Hub was largely a function of the civil servants. It was an immediate and direct response to the challenges and the need to acquire more material to support health services and other services who required PPE. It was agreed to create a PPE Hub as a one-stop shop to make sure that all offers of support and materials were brought under one roof with various agencies interacting with each other to ensure that all offers were properly assessed and all opportunities were properly explored.

Scotland Wales and Northern Ireland wrote to the UK Govt expressing our collective concerns regarding the limited supply of PPE being delivered through the UK-wide procurement approach. Scotland, Wales and ourselves had to pursue our own options. There was a concern that the further you are from the centre, the less your needs are heard or provided for. Generally, we had the sense of being politely entertained but not really listened to in most matters that we brought to central government in Whitehall. A centralised response has to be more cognisant of the particular demands of the regions, then I think would be of benefit. My general sense of dealing with Whitehall was of getting an audience but not having any impact in terms of decision making.

We do have a very strong manufacturing base in Northern Ireland and one which has some international reputation. We don't have natural materials in terms of supplies so that will always be a challenge for us.

Major General Phillip Prosser (Ministry of Defence, former deployee to NHS England PPE Team)

As early as the end of January we heard about demand management being put in place because our people are starting to order more than they ever have. The open areas in the distribution centres were becoming fuller so you couldn't break down the deliveries that arrived from the supplier. If you lack the open space, it is harder to get supplies out from the distribution centres. We worked long hours, to put temporary warehousing up outside with tents, etc to make some space. They did that in one to two weeks.

There didn't seem to be a plan for what happened after we created that space. Neil Ashworth, who used to be a Chief Commercial Officer, suggested Clipper Logistics to deliver stock. Their market was the High Street which was down because of the pandemic, so they had capacity. He introduced us. Clipper Logistics were awarded contracts worth around £200 million. There was no open procurement process and Clipper was not on the Crown Services Commercial service list. I don't think Mr Ashworth reached out to any other logistics companies, but he did mention Clipper specifically because they were known to have the agility to do things quickly.

I can't hide from the fact that there were demand and supply chain challenges. We didn't have visibility of frontline stock. We never used the word *"rationing"*, we used the phrase *"centralised distribution to meet demand on a short-term basis."* Rationing would imply that we've got stuff and we're holding it back. We very rarely held stuff back. In April and May it was very much hand to mouth.

David Williams (Former Director General and Second Permanent Secretary, Department of Health and Social Care).

By the time they got to me, deals had been through quite a rigorous process of commercial evaluation, quality assurance, technical evaluation and financial assurance. If there were issues that would have prompted me to want to say no, they wouldn't have come to me. I can't think of any deals that I personally rejected. I can think of deals where I've asked for further clarification or confirmation.

My personal regret is that bordering on unacceptable behaviour and pressure was being put on members of the Buy Team in particular. Whilst some of it was escalated to senior officials working for me, not much of that got to me very early in the period. I think senior engagement with some suppliers, or with some of the more persistent referrers, to say, enough now. Whether it's guidance or whether it needed was senior intervention to say, "You've just got to stop, we're going to process the deal, it's going to be assessed fairly against criteria, we'll come back to you when we need more information", I personally regret that I wasn't more in that space. In some ways it's only in preparing for some of the session today and for some of the witness statement that I've appreciated some of that pressure that my team were under.

Closing statements

Anna Morris on behalf of CBFFJ UK

Politicians have sought to paint a picture to this Inquiry that only they lived in “the real world” which the rest of us could never understand in terms of the pressures, decisions and difficult phone calls they had to make in procuring PPE. They claim that the PPE procurement exercise was an unmitigated success and that they would not do anything differently.

In the real world, clinicians were faced with difficult choices as to how to treat patients, and as Professor Moonesinghe recognised, it is possible that the pressure of a lack of essential lifesaving equipment, like ventilators, may have changed the way that clinicians thought about how to escalate some critical care patients. Something that many of the families that we represent experienced.

On the VIP Lane Michael Gove went as far as to say that it was a required aspect of democratic accountability for politicians to refer and chase offers made by people that they knew and in a significant number of cases stood to benefit directly from. This is not ministers acting within their specialist portfolio checking that all that could be done was being done by civil servants. This was ministers and politically exposed people with no expertise in procurement, or worse, politicians who were likely to directly benefit from the award of contracts, applying undue pressure to those processing offers within the VIP Lane.

As we set out in the preliminary hearing to this module, we have always maintained that this Inquiry needed to investigate relevant contracts from offer through to conclusion. This would have involved hearing from those who were processing the offers in the VIP Lane such as that from SG Recruitment at every stage. In fact, the Inquiry hasn’t called any evidence from those conducting the due diligence checks, the closing team or anyone within the Technical Assurance Team. The effect of this is that each of the witnesses the Inquiry has heard from have been able to say that they expected someone else to have ensured that all the necessary checks were done.

As Prof Sanchez Graells concluded, the VIP Lane was an affront to good procurement. Mr. Gove, Mr. Hancock and other politicians have sought to undermine Professor Sanchez Graell’s evidence. But he is the pre-eminent expert in procurement. The Politicians can’t get around the criticisms in his evidence,

so they have resorted to personal diatribes, accusing him of a “flawed analysis” without providing the Inquiry with any proper legal or academic challenge to his findings.

The Inquiry should be concerned about this approach and what it says about a culture of learning within government. We endorse Professor Sanchez Graell’s view that the fact that all this time later those involved don’t recognise that billions of pounds were spent unlawfully speaks of a dysfunctional culture of lesson learning. It is also now well known that 50% of the companies channelled down the HPL route provided PPE that was not fit for purpose, and the Inquiry has not heard from a single witness or called a single supplier to answer to this waste of money and resources. Overall, the government's inadequate preparedness and inefficient procurement systems resulted in a £3.8 billion of wasted PPE that could not be used in the NHS.

The public expected its government to secure adequate amounts of appropriate PPE to protect our diverse health and social care and public sector and to protect the already stretched public purse from fraud, profiteering and cronyism.

Brenda Campbell KC ob behalf of NI CBFFJ

The UK and devolved entities were not ready: Procurement provision and supply chains were not set up to enable effective responses for a pandemic. Inventory management systems did not exist or were not up to the task at hand. Stockpiles were out of date or wholly insufficient. Co-ordination across the UK and the DAs was, as ever, on the hoof, superficial and the source of frustration

A process that was more focused on triaging people rather than product, a system that was ripe to be highjacked by shysters and fraudsters at huge financial, political and human cost that will be felt for generations to come.

The reality is a system of triage for so called VIPs was not necessary. It was not something followed in the devolved jurisdictions, nor in other nations. The problems faced in London were not unique. Shamefully, the response to them was.

A glaring problem with the VIP Lane is that it should have been clear at the time that establishing a two-tier system based on political connections or cronyism was wrong. But the most glaring problem with the VIP lane is that it was not a successful system. And that is a really important point. We might not be so troubled by the opportunists making vast amounts of money if the system had worked but that fact that it did not, makes that opportunism much, much worse.

The bereaved are not – as Lord Agnew appeared to suggest – whipped up by false narratives or headlines of a heinous plan by those in power to enrich themselves or their mates. Theirs is a legitimate and deep-seated anger borne out of the failings they witnessed and the loss they experienced as a result. But it is also an anger at the failure to prepare and the establishment of a system that enabled profiteering and cronyism while Rome burned. And why shouldn’t they be angry. The evidence you have heard in this

module, does a disservice to the UK, to those who did their best within a rotten system, to those who died and to those who carry on in grief.

UKACC

Former Secretary of State for Health, Matt Hancock claimed that asking challenging questions about his decisions was naive because "you had to be there". Well, we were there. My organisation, the Open Contracting Partnership, was directly involved in helping other countries with their pandemic procurement response. We also published constructive suggestions based on the strategies of 100 experts on 20th March 2020. There were so many sensible, professional and more obvious procurement approaches that the UK could have taken but didn't.

Who you knew mattered more than what you knew, or what supplies you had. As we have heard through the government's own audits and the Inquiry's own evidence, you were over ten times more likely to get a deal if you made the VIP Lane.

We evidenced that the VIP Lane deals had a higher failure rate than other sourcing. You can't have it both ways. If you care about PPE and saving lives, you need a professional structured process that delivers results, not hugely risky contracts with untested suppliers, some of whom didn't even exist a few days before getting a contract.