House of Commons

Public Accounts Committee

COVID-19: Government procurement and supply of Personal Protective Equipment

Forty-Second Report of Session 2019–21

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 4 February 2021

HC 928
Published on 10 February 2021
by authority of the House of Commons

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The shortages of personal protective equipment at the front-line in the first wave of the pandemic was one of the biggest concerns in March and April 2020. As well as NHS front line workers there were others front-line workers who required high grade PPE – particularly in social care settings, which were mainly private businesses.

At each stage the Department for Health and Social Care maintain that no setting actually ran out of PPE. We heard compelling evidence from organisations representing front-line workers that stocks ran perilously low; single use items were reused; some was not fit for purpose and staff were in fear that they would run out.

Government thought it was well-placed to manage the COVID-19 pandemic because it had a plan and a stockpile of personal protective equipment. However, these were designed for an influenza pandemic and the plans, stockpile and PPE distribution arrangements were inadequate for a coronavirus pandemic. The NHS's existing suppliers of PPE (mostly from overseas) could not increase supply quickly enough to meet the extreme demand and urgency of the global situation. As well as the urgent need to procure PPE, government also needed to procure a wide range of other goods and services quickly during the pandemic. By 31 July 2020, it had awarded over 8,000 contracts for goods and services, such as PPE and professional services, in response to the pandemic, with a value of £18 billion.

Government faced significant challenges in having to work at pace, using emergency procurement procedures, in a competitive international market. However, its failure to be transparent about decisions, publish contracts in a timely manner or maintain proper records of key decisions left it open to accusations of poor value for money, conflicts of interest and preferential treatment of some suppliers, and undermines public trust in government procurement and the use of taxpayers' money. Between February and July 2020, the Department of Health and Social Care spent over £12 billion on 32 billion items of PPE. We are concerned that the Department has so far identified items worth hundreds of millions of pounds which are unusable for their intended purpose, putting the efficient use of taxpayers' money at further risk.

Early in the pandemic, the Department of Health & Social Care lacked information on how much PPE was needed by health and social care providers and which ones had the greatest need. Its decision to prioritise hospitals meant social care providers did not receive anywhere near enough to meet their needs, leaving them exposed. Many workers at the front line in health and social care were put in the appalling situation of having to care for people with COVID-19 or suspected COVID-19 without sufficient PPE to protect themselves from infection.

The Cabinet Office is still too defensive about the lack of transparency over contract awards. We would welcome an honest understanding that, despite best endeavours in procuring vital equipment, it is necessary to be open and transparent about why decisions were made and contracts awarded.

The Department of Health and Social Care must develop a better understanding of the needs of both NHS organisations and, crucially, allied health and social care sectors – an issue this and predecessor committees has raised before the pandemic.

Introduction

In responding to the COVID-19 pandemic, government departments and public bodies have needed to procure enormous volumes of goods, services and works with extreme urgency, particularly personal protective equipment (PPE). But the pandemic had an extraordinary impact on global demand for, and supply of, PPE. Demand rocketed in March 2020 and, at the same time, global supply declined. The result was an extremely overheated global market, with desperate customers buying huge volumes of PPE often from new suppliers and pushing up prices. The Cabinet Office issued information and guidance on public procurement regulations in response to the pandemic, highlighting that departments and public bodies were able to procure goods, services and works with extreme urgency using regulation 32(2)(c) of The Public Contracts Regulations 2015. The regulation allows departments and public bodies to make direct awards of contracts to any supplier if they have an urgent requirement for goods, services or works due to an emergency, without undergoing a formal competition, subject to meeting certain criteria.

By 31 July 2020, the government had awarded over 8,000 contracts for goods and services in response to the pandemic, with a value of £18 billion. Most of these contracts (over 6,900) were for PPE. The PPE contracts had a combined value of more than £12 billion and committed the Department for Health and Social Care (the Department) to buying 32 billion items of PPE. The Department intended to build up a stockpile of PPE that could last four months, in addition to meeting immediate needs. To identify suppliers which could provide this PPE, to support new UK manufacturers that had not previously made PPE, and to distribute the PPE to care providers, the Department created a parallel supply chain.

Conclusions and recommendations

1. **Government's response to the need to very quickly procure PPE and other goods and services opened up significant procurement risks.** Government made extensive use of emergency procurement regulations to procure more than £10 billion of goods and services without competition. For fast procurements where there is no competition, it is important that awarding bodies document why they have chosen a supplier and how any associated risks from a lack of competition have been identified and managed. However, there are examples where departments failed to document why they were using emergency procurement, why particular suppliers where chosen or how any potential conflicts of interest had been identified and managed. Transparency also helps to ensure accountability for procurement decisions, particularly when no competition is involved. However, the details of fewer than half of the contracts awarded before the end of July with a value over £25,000, had been published by 10 November, and only 25% were published on Contracts Finder within the government's target of 90 days. In December 2020, the Cabinet Office published the Boardman review into its COVID-19 communications services contracts, which made 28 recommendations to improve the Cabinet Office's procurement processes and the way government manages actual and perceived conflicts of interest. The Cabinet Office has accepted all 28 recommendations and committed to implementing most of them within six months. It is puzzling why the plans for emergency procurement did not include a stronger understanding of the need for transparency and proper record keeping from the outset.

   Recommendation: ***Government should ensure all the Boardman review recommendations are applied across government departments and procuring bodies. The Cabinet Office should write to us by July 2021 outlining its progress in implementing the recommendations of the Boardman review and a timetable for implementing any outstanding recommendations.***

2. **While government had plans and a stockpile of PPE, this proved inadequate for the COVID-19 pandemic.** The Department had a strategy for managing an influenza pandemic, which included a stockpile of PPE owned and managed by Public Health England. In March 2020, NHS England & NHS Improvement gave public assurances to the Health and Social Care Committee that the stockpile would be sufficient to manage the pandemic, but this confidence was misplaced since the stockpile held no more than two-weeks' worth of most types of PPE. Furthermore, it did not hold all of the planned PPE, such as visors and gowns, and some of the PPE it did hold had expired or did not meet current safety standards. Government and its contractors also struggled to distribute the stockpiled PPE quickly. In response to these problems the Department created a parallel supply chain to buy and distribute PPE. However, because of the time lag between ordering PPE and it being available, this could barely satisfy local organisations' requirements. Frontline staff in health and social care experienced shortages of PPE, with surveys by staff representative organisations showing that at least 30% of participating care workers, doctors and nurses reported having insufficient PPE, even in high-risk settings. Provider organisations attempted to buy PPE at short notice, in an overheated market, and

found they needed to pay hugely inflated prices to suppliers they were unfamiliar with. The PPE from central government was sometimes not usable and providers told us that emergency helplines referred them to suppliers which did not have PPE.

Recommendation: ***The Department must improve its approach to managing and distributing stocks of PPE to ensure the correct equipment gets to those who need it, when they need it. The Department should write to us by July 2021 to confirm that:***

- ***Stockpiles hold everything required as specified in the Department's plans.***
- ***Stock is checked regularly and there is a process for monitoring and replacing stock before it is out-of-date.***
- ***Stock is held in locations from which it can be distributed quickly when required***
- ***There are contingency plans to secure new items of clinical equipment which may be needed at short notice***

3. **The high-priority lane was not designed well enough to be a wholly effective way of sifting credible leads to supply PPE.** Government's PPE buying team, within the parallel supply chain, received over 15,000 offers to supply PPE. This cross-government PPE buying team set up a high-priority lane to separately assess and process high-priority leads that it considered more credible, which sat alongside an ordinary lane to process other leads. Leads that were considered more credible were those from government officials, ministers' offices, MPs and members of the House of Lords but it is not clear why this assumption was made. The priority lane did not include organisations with expertise in the health and social care sector that had existing relationships with suppliers through their members or directly and were well-placed to assess the credibility of potential PPE suppliers, such as the British Medical Association. Around one in ten suppliers that came through the high-priority lane were awarded a contract compared with one in a hundred for the ordinary lane. There were no written rules to support those making referrals in deciding which leads to put forward. Some of those making referrals that were considered high priority, such as MPs, passed on leads on the basis that others would assess their suitability rather than vouching for the credibility of those offers. The same eight-stage process for assessing and processing offers was applied to both lanes, but the Cabinet Office and the Department accepted that leads that went through the high-priority lane were handled better.

Recommendation: ***The Cabinet Office and the Department should by July 2021 publish the lessons it has learnt from the procurement of PPE during the pandemic for future emergencies and disseminate these lessons to the wider government commercial function. This should include guidance for determining what is considered a credible offer and how this is communicated to potential suppliers.***

4. **The Department's focus on supporting hospitals meant assistance to social care providers was neglected.** The pandemic has shown the tragic impact of delaying much needed social care reform and treating the sector as the NHS's poor relation. This is an issue this Committee has raised concerns about before when we examined

the Department's approach to readying the NHS and social care for the COVID-19 peak, and in our earlier examinations of the interface between health and social care and on the adult social care workforce. The Department provided NHS trusts with 1.9 billion items of PPE between March 2020 and July 2020, equivalent to 80% of their estimated need. In contrast, it provided the adult social care sector with 331 million items of PPE, equivalent to10% of its estimated need. Social care representatives told us their usual suppliers could not provide PPE, in part because some of it was diverted to the NHS, and consequently some providers ran out of PPE. Some 25,000 patients were discharged to care homes from hospitals, some without being tested for COVID-19, even after it became clear that people could transmit the virus without having symptoms. This contributed significantly to the deaths in care homes during the first wave. Social care was only taken seriously after the high mortality rate in care homes became apparent. Key workers outside of health and social care, including transport and supermarket workers, security guards and taxi drivers, were not provided with PPE, yet doing so could have prevented them becoming ill or passing on the virus.

Recommendation: ***The Department should write to the Committee by the end of April 2021 to explain how it will revise its emergency response plans so that they include who will be supported, how and when. This must give appropriate weight to all sectors of health and social care, as well as occupations outside these sectors which are also at risk.***

5. **The Department does not know enough about the experience of frontline staff, particularly BAME staff.** The Department set up a daily process for gathering information about the PPE required by local organisations and maintains that its formal reporting arrangements did not identify any provider organisation, in health or social care, as having run out of PPE. Despite this, Care England is clear that some social care providers did run out of PPE, and representative organisations' surveys showed staff reported PPE shortages. In a survey by the Royal College of Nursing many nurses reported being asked to reuse single-use items of PPE. Frontline staff found the multiple iterations of guidance confusing and were concerned that the guidance did not specify a high enough level of PPE to properly protect them. Black, Asian and minority ethnic (BAME) staff were more likely to report experiencing PPE shortages, feeling pressured to work without adequate protection, and not being fit tested for respirator masks. A third of BAME doctors reported experiencing PPE shortages compared with 14% of white doctors, Similarly, almost half of BAME nurses said that they had not been fit tested for respirator masks compared with 74% of white nurses. By October 2020, employers had reported 126 deaths and 8,152 diagnosed cases of COVID-19 among health and care workers as being linked to occupational exposure. The Department asserts that there is no evidence that these deaths were caused by PPE shortages, but confirmed that medical examiners will fully investigate the death of all staff within trusts to determine whether this has been the result of occupational exposure to the virus.

Recommendation: ***The Department needs to better understand the experience of frontline staff during the first wave of the pandemic, and ensure lessons are learned so it can better respond in a future emergency. It should particularly focus on the different reported experiences of staff from different ethnic backgrounds***

and consider how this should be monitored and tackled in future – not just in a pandemic. It should write to us by July 2021 setting out the results of this work and how these lessons are being applied. This work should cover:

- ***How many health and social care providers ran out of each type of PPE during the pandemic.***
- ***Why many health and social care staff reported shortages of PPE, whereas the organisations they worked for did not appear to report shortages.***
- ***The extent to which (and reasons why) BAME staff were less likely to report having access to PPE and being tested for PPE, and more likely to report feeling pressured to work without adequate PPE.***
- ***Whether there are any links between PPE shortages and staff infections and deaths (when the relevant investigations have completed), including the deaths of health and care workers who do not work in NHS trusts.***
- ***Provider organisations' and frontline staff views on PPE guidance.***

6. **We are concerned that the Department's ordering of an enormous amount of PPE might compromise government's ambition to maintain a UK manufacturing base for PPE.** Between February and July 2020, the Department ordered 32 billion items of PPE. It intended to build up a stockpile that could last four months. Based on the rate PPE was used between March and July 2020, the amount of PPE that the Department has ordered could last five years (with variations across different types of PPE). Government's PPE strategy aims to build a UK manufacturing base so that there is a resilient domestic supply. But there is a risk that UK manufacturers of PPE will be unable to sell in the UK if the Department has over-ordered PPE supplies. The Department asserts that this does not mean that it has overordered, since the PPE it has ordered could be used to support primary care and social care and might also be needed for its testing and vaccination programmes and future waves of the virus. The Department has nonetheless committed to considering whether some of its PPE contracts could be reduced or cancelled, and whether it could share or sell some PPE.

   Recommendation: ***The Department, working with other government departments where necessary, should set out a plan by July 2021 that shows how it will:***

   - ***Use the PPE it has ordered, covering how much will be given health and social care providers, stockpiled, cancelled, or sold in the UK or overseas.***
   - ***Incentivise the NHS Supply Chain, trusts and other providers, to buy PPE which is made in the UK.***
   - ***Ensure there is sufficient resilience in the supply chain where UK manufacturers cannot provide the necessary PPE.***

7. **The Department has wasted hundreds of millions of pounds on PPE which is of poor quality and cannot be used for the intended purpose.** The urgent need for PPE meant it accepted more risks when buying PPE than it usually would. At the time of our evidence session, some 195 million items of PPE, equivalent to

around 1% of those received to date, had been identified by the Department as being potentially unsuitable for their intended purpose. The Department hopes that some of this can be used for other purposes. It now estimates that only 0.4% of the PPE it has received failed to meet safety standards and therefore cannot be used at all and that 1.3% of items were not fit for the intended purpose. It has not yet estimated the amount of money that has been spent on potentially unusable items, but this will amount to hundreds of millions of pounds. The Department told us told us that its PPE contracts contain clauses which allow it to reclaim costs for substandard PPE or PPE that was not provided, but it could not tell us how many of these contracts it was pursuing or how much progress it had made.

Recommendation: ***The Department should write to the Committee by July 2021 setting out how much of the PPE it ordered it has received and checked, and the volumes and costs of the PPE that (a) cannot be used at all; (b) cannot be used for its intended purpose; and (c) its methodology for determining the volumes and costs of PPE which it considers to be in each of these categories.***

8. **It should also update us on the number of contracts (and their financial value) in which it is seeking to recover costs for undelivered or substandard PPE.**

1 Government's approach to procurement during the pandemic

1. On the basis of two reports by the Comptroller and Auditor General, we took evidence from the Cabinet Office, Department of Health & Social Care (the Department) and Public Health England about government procurement during the COVID-19 pandemic and the supply of personal protective equipment (PPE).[1] As part of our inquiry, we also took evidence from Care England, the British Medical Council, the Royal College of Nursing, and UNISON.

2. Government was required to react with urgency in response to the COVID-19 pandemic and as part of this departments and public bodies were required to procure new goods and services. By 31 July 2020, government had awarded over 8,000 contracts in response to the pandemic, with a value of £18 billion. The Cabinet Office issued information and guidance on public procurement regulations in response to the pandemic. This included Procurement Policy Note 01/20, which highlighted to departments and public bodies that they were able to procure goods, services and works with extreme urgency using regulation 32(2)(c) of the Public Contracts Regulations 2015. The regulation allows departments and public bodies to make direct awards of contracts to any supplier if they have an urgent requirement for goods, services or works due to an emergency, without undergoing a formal competition, subject to meeting certain criteria.[2]

3. The largest proportion of government's spending, over £12 billion, was on the purchase of PPE. PPE is vital during the pandemic to protect its users in the health and social care services and elsewhere from catching COVID19 from contact with other people, and to help protect patients against onward transmission. COVID-19 has had an extraordinary impact on global demand for, and supply of, PPE. From March 2020, demand for PPE rocketed in England and across the world while the overall global supply fell. Where government required PPE, it therefore had to buy it in a difficult and uncertain market.[3]

Failures to address procurement risks

4. Government awarded contracts worth more than £10 billion without competition and made extensive use of emergency procurement regulations to very quickly make direct awards of contracts. The NAO found that this opened up significant procurement risks, including increased risks of unequal treatment of suppliers and poor procurement processes. In the absence of competition, other measures such as increased transparency and clear documentation of decisions become even more important than in normal circumstances to ensure public trust is maintained.[4] Many of the risks materialised. These included only conducting due diligence on suppliers of PPE after already awarding them

1 Report by the Comptroller and Auditor General, *Investigation into government procurement during the COVID-19 pandemic*, Session 2019–2021, HC 959, 26 November 2020; Report by the Comptroller and Auditor General, *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, Session 2019–2021, HC 961, 25 November 2020

2 Qq 162–165, 202; C&AG's Report *Investigation into government procurement during the COVID-19 pandemic*, paras 1.2–1.5, 2.2–2.5

3 Qq 117, 118; C&AG's Report *Investigation into government procurement during the COVID-19 pandemic*, figure 5; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 1–2

4 Qq 148, 200; C&AG's Report I*nvestigation into government procurement during the COVID-19 pandemic*, paras 2.5, 3.2, 3.6

contracts, and retrospectively awarding other contracts months after work had begun. The Cabinet Office backdated approval for a £3.2 million consultancy contract with Deloitte for support to the PPE supply chain. We asked whether this posed an unacceptable risk for large amount of taxpayers' money. The Cabinet Office was unable to tell us how many contracts had been awarded retrospectively in this way and accepted that there had been a lack of transparency over the contracts.[5]

5. The NAO also found cases where departments failed to document why they were using direct awards and not using competition to buy goods or services, or why particular suppliers were chosen. In other cases, departments failed to properly document potential and perceived conflicts of interest and how they managed them, particularly in circumstances where ministers held cross-cutting responsibilities.[6] The Cabinet Office explained that there were well established procedures across government to manage conflicts of interest and confirmed that the emergency procurement procedures did not remove Departments' responsibility to manage these. It accepted that while the NAO report did not find any evidence of conflict of interests through Ministerial involvement, the evidence of how conflicts had been managed was not as clear as it should be. It similarly recognised that being able to overtly show how it had managed conflicts of interests would be crucial to maintaining public trust.[7]

6. Departments failed to meet targets to publish basic information on contract awards within 90 days of the award being made. For contracts awarded before the end of July with a value over £25,000, less than half had their details published by 10 November, and only 25% were published on Contracts Finder within the government's target of 90 days.[8] The Cabinet Office admitted that it had taken too long to publish contract award notices, and that the backlog in publishing award notices was not prioritised as much as the actual procurement. The Cabinet Office told us that most contracts had now been published and the Department added that all the PPE contracts had now been published.[9]

7. In December 2020, the Cabinet Office published the Boardman review into two of its COVID-19 communications services contracts that had been let during the pandemic. Although the report focused on a specific area, it reported wider findings and recommendations, and noted that its findings were consistent with those of the National Audit Office's procurement report.[10] The Boardman report contained 28 recommendations covering the Cabinet Office's procurement processes and the way government manages actual and perceived conflicts of interest. The Cabinet Office told us that it had accepted all 28 recommendations. We asked when the Cabinet Office expected to have implemented these recommendations. The Cabinet Office told us that it had already started implementing some of the recommendations, such as those relating to desktop guidance and providing additional training. It explained that some of the recommendations, such as creating a searchable cross-government database of potential conflicts, would take a little longer to put in place and it had given itself six months to implement most of the recommendations.[11]

5 Q 170, 224–228; C&AG's Report *Investigation into government procurement during the COVID-19 pandemic*, paras 18, 21

6 Qq 114, 198–211; C&AG's Report *Investigation into government procurement during the COVID-19 pandemic*, para 20

7 Qq 199–202, 204

8 Q 215; C&AG's Report *Investigation into government procurement during the COVID-19 pandemic*, paras 18, 23

9 Qq 87, 204, 215–222

10 *Boardman Report on Cabinet Office Communications Procurement*, 8 December 2020

11 Qq 114–115, 200–203, 207

High-priority lane

8. As the scale of the challenge to supply the required PPE became clear, the Department created a parallel supply chain to identify suppliers that could provide PPE, to support new UK manufacturers that had not previously made PPE, and to distribute the PPE to NHS and social care providers. This became operational at the beginning of April.[12] In response to government's call for offers to provide PPE, the parallel supply chain received over 15,000 offers of support.[13] It established an ordinary lane to assess and process the majority of these offers and a high-priority lane to separately assess and process leads that it considered more credible. Both lanes used the same eight-stage process to assess and process offers. However, the Cabinet Office noted that leads that went through the high-priority lane were handled better and that the parallel supply chain team 'held their hands' through the process. Around one in ten suppliers which came through the high-priority lane were awarded a contract compared with one in a hundred for the ordinary lane. The Cabinet Office told us that the total value of contracts awarded to suppliers through the high-priority lane was £1.7 billion.[14]

9. Access to the high-priority lane was based on recommendations coming from government officials, ministers' offices, MPs and members of the House of Lords. The NAO found that there were no written rules which determined the basis on which suppliers should be recommended for the lane, meaning that it was left to the judgment of individuals putting forward the leads. Committee members noted that when MPs passed on leads they were not necessarily based on personal experience or expertise in PPE procurement and therefore not in a position to vouch for the validity or credibility of the lead. The NAO found that the process did not clearly record information on referrals. The Cabinet Office confirmed that of the 47 suppliers which came through the high-priority lane and were awarded contracts, 12 were introduced from MPs, seven from Peers and 18 from officials. In five cases, the source of the referral was not known and one referral was put in the lane in error. Although the lane was established for more credible leads, the Department admitted that in practice it was a convenient way to make sure offers were getting picked up in a way that it could then explain back to MPs or others that they were being looked at.[15]

10. The British Medical Association and the Royal College of Nursing told us that their organisations did not have access to the high-priority lane, even though they were being contacted by, and therefore would have been able to put forward, credible leads based on the knowledge of their members. The British Medical Association also noted that suppliers which had contacted them, including suppliers trusted by doctors, tried the normal channels of reaching out to the Government but had "hit a brick wall". Care England told us that it had similarly shared the details of potential suppliers but there had been no follow-through. The Department was unable to confirm whether the British Medical Association had access to the high-priority lane and committed to checking this.[16]

12 Qq 117–118, 134, 144, 272; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 10, 2.2, Figure 6

13 Qq 89, 149, 179, 191

14 Qq 179–188

15 Qq 179, 180, 182, 186; 191–192; C&AG's Report *Investigation into government procurement during the COVID-19 pandemic*, paras 3.12–3.14, Figure 6

16 Qq 46–47; Qq 181–184

Volumes of PPE procured

11. Between February and July 2020, the Department ordered 32 billion items of PPE. The Department told us that it was seeking to avoid shortages in the event of a potential second wave and had deliberately looked to build up a stockpile equivalent to four months' usage across all lines of PPE. It also told us that the model this was based on was cautious and that other types of usage would increase. However, the NAO found that if PPE was to be used consistently at the rate it was used between March and July 2020 at the peak of the pandemic, about 503 million items per month, the PPE ordered could last around five years (with variations across different types of PPE). We asked how the Department would ensure that its stockpile was properly managed so that none of the PPE would be wasted or go out of date. The Department assured us that it was committed to ensuring this was the case.[17]

12. Government's PPE strategy aims to build a UK manufacturing base so that there is a resilient domestic supply. The Department explained that 70% of PPE (excluding gloves) that it expected would be supplied between December 2020 and February 2021 should come through contracts set up under the Department's UK Make programme. It cited contracts for this programme as one of the reasons that the number of orders it made peaked in June, after the initial pandemic peak. We were concerned that this domestic production risked being undermined by surpluses of PPE and asked whether it would need to consider reducing its existing contracts. The Department explained that some of the PPE stocks were of items such as aprons and gloves which the sector used in high volumes, but accepted there was a bigger challenge for other types of PPE such as respirator masks.[18]

13. The Department asserted that while it had deliberately secured a significant stockpile of PPE, it was not clear it had over-ordered as the stock would be needed for the ongoing COVID crisis. It admitted that it did not have full information about how much PPE had been provided by suppliers outside the parallel supply chain. Additional PPE was also used by staff who were not treating known COVID19 NHS patients but were supporting the 'reopening of the NHS'. It also told us that the PPE it had ordered can be used to support primary care and social care and might also be needed for the programmes to test people for, and vaccinate people against, COVID-19. Not all of the PPE purchased had yet been delivered and the Department told us it would consider whether some of its PPE contracts could be reduced or cancelled. The Department also said that it was looking at sharing or selling some PPE with its partners.[19] The Department wrote to us after our evidence session and told us that to date it had, for a multitude of reasons, cancelled or curtailed contracts to the value of around £400 million.[20]

Problems with the quality of some PPE procured

14. Not all of the PPE the Department bought can be used. The Department told us that only 0.5% of the 18 billion items of PPE it had received and checked so far had failed to meet clinical safety standards and therefore could not be used at all. However, this figure

17 C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, para 2.26; Qq 193–196, 232, 267–269

18 Qq 193–197, 270–271; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 4.5, 4.10

19 Qq 194–197, 248, 267–268

20 Letter from Department of Health & Social Care, 15 January 2021

is not complete, both because the calculation does not include PPE which the Department hopes to use for different purposes to that for which it was intended, and because much PPE is yet to be received or tested. The Department accepted that this figure would change as it finished its process of checking. The NAO report found that the Department had identified 195 million items of PPE that were unusable or potentially unsuitable, which would be around 1% of the items received to date.[21] The Department explained that this included a wider group of products, including those which could not be used for their intended purpose but could be used in other ways.[22] In its letter after our evidence session, the Department stated that its updated estimate was that 1.3% of the items bought were not fit for the original intended purpose and that 0.4% were not fit for any purpose. The letter did not provide information on the number of items tested to date.[23]

15. The Department had not calculated the value of unusable or potentially unsuitable items but told us that it was currently undertaking work to estimate this and committed to coming back to us with a timetable for when this would be complete.[24] It told us that it was investigating potential fraudulent activity and acknowledged that while the levels of fraud were very low, the costs could run to millions of pounds. It told us that its PPE contracts contain clauses which allow it to reclaim costs for substandard PPE or PPE that was not provided, but it could not tell us how many of these contracts it was pursuing or how much progress it had made. The NAO reported the value of potentially unusable items will amount to hundreds of millions of pounds.[25]

16. The Department accepted that the urgent need for PPE meant it accepted greater risks when buying PPE than it usually would. The Department maintained, however, that it did not ask the Health and Safety Executive to lower standards. It told us that it bought millions of FFP2 respirator masks which did not meet government's published safety standards because it was concerned it would run out of FFP3 respirator masks. It explained that it was in discussions with the Health and Safety Executive about changing that standard to permit the use of these particular FFP2 masks. FFP2 masks of the type the Department bought were then not permitted to be used for their original intended purposes.[26]

21 C&AG's Report T*he supply of personal protective equipment (PPE) during the COVID-19 pandemic*, para 2.20, Q92

22 Qq 247–254

23 Letter from Department of Health & Social Care, 15 January 2021

24 Qq 252–254

25 Qq 92–102, 173–178, 249–251, 255–256; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 2.19–2.20

26 Qq 148–149, 176–177, 234–246; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 2.19–2.20

2 Government supply of PPE during the pandemic

Government readiness for the need to supply PPE during the pandemic

17. Government had a Pandemic Influenza Preparedness Programme and a stockpile of PPE for managing an influenza pandemic, but not a coronavirus pandemic (such as COVID-19). Public Health England told us this was because the national risk register identified an influenza pandemic as the number one risk. Public Health England owned and managed the PPE stockpile for an influenza pandemic on behalf of the Department, and the Department also had a smaller stockpile of PPE to manage a 'no deal' exit from the European Union.[27]

18. In March 2020, officials from NHS England & NHS Improvement publicly assured the Health and Social Care Select Committee that these stockpiles meant the country was well placed to manage the COVID19 pandemic. However, the NAO report found that the stockpiles provided no more than two-weeks' worth of most types of PPE needed by the NHS and social care during the pandemic and did not hold all the PPE they had been expected to hold (such as visors and gowns). Some of the stockpiled PPE had also passed its expiry date or did not meet current safety standards. Furthermore, government (and its contractors) struggled to distribute the stockpiled PPE as quickly as the situation required.[28]

19. The Department told us that it had not been complacent over the stockpiles, but that COVID-19 was a novel virus and it learned more about it over time. Unlike influenza, COVID-19 can be passed on by people who are not showing symptoms of the illness. The Department explained that this meant government needed to provide PPE to a much larger group of people to stop the spread of the virus. It also said that while there were vaccines and antiviral medication available for managing influenza, this was not the case with COVID19, and that government did not have the gowns needed for managing COVID-19 because its infection control policy had been to use aprons rather than gowns.[29]

The experience of frontline organisations

20. Almost all the PPE was manufactured abroad and had to be shipped, flown or put on a train to the UK. This meant it took a long time to be delivered. Therefore, despite the creation of the parallel supply chain, the time lag between ordering PPE and it being available, the Department could barely satisfy local organisations' requirements.[30] Representatives of the frontline of health and social care sector told us they experienced various problems accessing the PPE they needed, and in some cases could not access it

27 Qq 109–110, 116–118, 120, 146; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, Figure 3

28 Qq 13, 120, 145–146; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 8, 1.8–1.9, 1.14, 1.16, Figure 4; House of Commons Health and Social Care Committee, Oral evidence: *Coronavirus – NHS Preparedness*, Session 2019–2021, HC 36, 17 March 2020, Qq 129–132

29 Qq 144–147

30 C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 13 and 2.22, Figure 9

at all. The British Medical Association and the Royal College of Nursing told us that, in March and April, the PPE they ordered by providers through the NHS Supply Chain was not provided and when government did eventually provide PPE it provided only tiny amounts. Care England explained that providers had to buy their own PPE at hugely inflated costs, buying from suppliers they were unfamiliar with and running the risk of being sold substandard PPE. The British Medical Association provided one example of paying £150 for five respirator masks which, as shown in the NAO report, would have cost around £1 each in 2019. Care England told us that the situation within the social care sector was even worse than the NHS, with established supply chains being disrupted and reports of PPE being redirected from social providers to the NHS. The Department assured us it did not did not make any 'contractual engagements' to divert PPE from social care to the NHS. The British Medical Association and the Royal College of Nursing told us that a helpline created to provide PPE to local organisations was sometimes unable to provide PPE and referred them to PPE suppliers that were also unable to provide PPE. They also told us that NHS organisations came very close to (sometimes within hours of) running out of PPE and Care England told us that some social care providers actually did run out of PPE and staff did not have the PPE that they needed.[31]

21. The Department explained that its formal reporting arrangements did not identify any provider organisation, in health or social care, as having run out of PPE completely. It monitored the risk that social care could run out within 48 hours. It told us the national supply disruption emergency helpline, which was available from mid-March, would supply immediately to any organisation which would run out within 24 hours.[32] The Department told us it had put in place a process to understand the PPE available to local organisations. This included daily calls with NHS regional officers (who in turn were liaising with individual trusts), with local resilience forums and with government's emergency helpline. We asked whether the Department triangulated this with information from the trade unions whose members may have reported a very different story about shortages. The Department noted it did have conversations with the Royal College of Nursing and the British Medical Association "at times", but its main source of information on access to PPE was the process of daily calls.[33] It acknowledged that its reporting mechanism for understanding how much PPE social care providers held was not all that it would have liked at the start of the pandemic but told us its data improved from around May.[34]

22. We have previously noted that the COVID-19 pandemic has shown the tragic impact of delaying much needed social care reform and integration with health, and instead treating the sector as the NHS's poor relation.[35] Between March 2020 and July 2020, the Department provided NHS trusts with 1.9 billion items of PPE, equivalent to 80% of their estimated need. Over the same period, it provided 331 million items to the adult social care sector, equivalent to 10% of its estimated need. Of the total PPE distributed between March and July, trusts received 81% and adult social care 14%.[36] The Department told us that this imbalance was a consequence of the arrangements for supplying PPE

31 Qq 8–10, 13–14, 17–18, 22, 29, 34, 37, 38, 40, 46, 66–67, 122

32 Qq 125–128

33 Qq 140–143, 156; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 2.5–2.6

34 Qq 131, 142–143, 156; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 2.5–2.6

35 House of Commons Public Accounts Committee, *Readying the NHS and social care for the COVID-19 peak*, Session 2019–2021, HC 405, 29 July 2020, para 3

36 C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, para 19

before the pandemic. Prior to the pandemic, social care providers tended to buy their PPE directly from wholesalers, while trusts tended to buy from the NHS Supply Chain. The Department told us its intention therefore was to provide PPE to social care providers as an "emergency top-up" when their usual suppliers could not provide it, rather than the Department becoming their main supplier. But social care representatives told us that providers were unable to get PPE from their usual suppliers or from the Department, and consequently providers reported shortages.[37]

23. Care England and the British Medical Association told us that the contingency planning process for a pandemic appeared to focus on the NHS at the expense of the social care sector despite some of the most vulnerable people being in social care. Care England told us this lack of planning included discharging 25,000 patients from hospitals into care homes, some without first testing them for COVID-19, even after it became clear that people could transmit the virus without ever having symptoms. In our report *Readying the NHS and social care for the COVID-19 peak* we previously highlighted that for around one month NHS trusts had been told to discharge medically-fit hospital patients before there was a policy to test patients for COVID-19 before discharging them to care homes. It considered this had contributed to the 20,000 deaths of people in care homes during the first wave of the pandemic. Care England told us that it was only after the high number of deaths became clear, that there was recognition that people in care homes were at the frontline of the pandemic.[38] Care England also highlighted the high mortality rates among people with learning disabilities and told us domiciliary care and learning disabilities services appeared to be of a lower priority than other types of care when PPE was being distributed. The Department told us that it had now set up an e-portal, and that over 80% of eligible social care providers, including care homes and domiciliary care agency, and primary care providers had registered to use it to obtain free PPE.[39]

The experience of frontline staff

24. Witnesses from organisations representing staff working in health and social care told us that providers received unusable PPE from central government. The Royal College of Nursing told us of instances where it had received masks on which the elastic was rotten, goggles which took significant amounts of time to assemble and were later recalled for being unsafe, and of opening a box of gowns to find insects inside. It also told us that it had received stock with stickers with dates showing the products had passed their expiry dates, and new stickers replacing these, with no explanation of any process to assure that the equipment was still safe. It noted that frontline staff were faced with unfamiliar-looking PPE and lacked confidence whether it was safe, and they were sometimes very frightened as a result. UNISON agreed that similar experiences were causing distress and anxiety to frontline workers.[40] In its letter to us after our evidence session, the Department stated that it had recalled and quarantined 40 million items of faulty PPE.[41]

25. Staff representative organisations ran surveys in which frontline staff reported not having the PPE they needed. The British Medical Association, the Royal College of

37 Qq 11, 17, 37–38, 66–67, 121, 123

38 Qq 11–12, 17, 23–24, 37, 66, 123; House of Commons Public Accounts Committee, *Readying the NHS and social care for the COVID-19 peak*, Session 2019–2021, HC 405, 29 July 2020, para 9

39 Qq 71–72 131, 194

40 Qq 14–16, 29–33, 39

41 Letter from Department of Health & Social Care, 15 January 2021

Nursing, the Royal College of Physicians and Unison ran surveys that showed at least 30% of participating doctors, nurses and care workers reported having insufficient PPE, even in high-risk settings.[42] Among the survey findings was that 51% of nurses reported being asked to reuse single-use items of PPE in a high-risk setting; 33% of Black, Asian or other minority ethnic (BAME) doctors felt they did not have the PPE they needed, compared with 14% of white doctors; and 49% of BAME nurses reported being fit tested for a respirator mask compared with 74% of white nurses.[43]

26. We asked about the experience of BAME staff and whether this had been different to that of their white colleagues. The British Medical Association told us that its surveys showed between two and three times as many BAME doctors as white doctors felt pressured to work without adequate protection. It also told us that it called for BAME staff to be given risk assessments in early April, when it became clear that COVID-19 was having a disproportionately high impact on staff from BAME backgrounds. But information from its members suggested that risk assessments were not being carried out until the end of May. The Department said that, since the initial PPE shortages, it had worked hard to listen to the concerns of BAME colleagues and ensure that all staff have a risk assessment. It also explained that it had a respirator mask fit-testing project and worked hard to ensure it could provide PPE in a range of sizes, so that everybody could get the PPE they needed.[44]

27. By October 2020, employers had reported 8,152 diagnosed cases of COVID-19 and 126 deaths as being linked to occupational exposure among health and care workers.[45] The British Medical Association and Unison asserted that the Department should investigate whether PPE shortages contributed to staff infections and deaths from COVID19. The Department told us that there was currently no evidence to show that shortages of PPE had contributed to staff deaths, but that that investigations were ongoing. It told us that all deaths in trusts are investigated by medical examiners, who refer to the Health & Safety Executive any cases where there is a chance that work-related exposure led to the death. The Health & Safety Executive will examine these cases, and the Department told us it awaited the outcome of this investigation and would act on its findings.[46]

28. Witnesses representing the health and social care sectors raised a number of concerns about the PPE guidance issued by government. The Department told us that it held conversations with the Royal Colleges (and with the NHS and public health services of the UK nations) about the PPE guidance issued.[47] The British Medical Association told us that, in March, the government guidance differed from the guidance of the World Health Organization: in particular government guidance did not recommend the use of eye protection in GP practices. Government did revise its guidance to recommend eye protection in early April. The NAO report stated that PPE guidance had been updated 30 times by 31 July, and the Royal College of Nursing highlighted that the frequency of changes was difficult for a provider organisation to manage and that the changes were

42 Qq 7–8, 11, 17, 49, 62, 142–143; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 18, 3.19–3.21, Figure 16

43 Q 49; Royal College of Nursing, Personal protective equipment: Use and availability during the COVID-19 pandemic (national survey results), 18 April 2020; C&AG's Report T*he supply of personal protective equipment (PPE) during the COVID-19 pandemic*, para 3.26

44 Qq 53–57, 260–261

45 C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 3.22–3.23, Figure 17

46 Qq 53, 276

47 Q 142

often issued late on a Friday with providers required to implement them from Monday. Care England and UNISON were concerned that the language of the guidance was not relevant for social care, and UNISON told us that government guidance permitting the re-use of masks led to many social care workers being required to wear the same mask for an entire 12-hour shift, which they felt was unsafe. The British Medical Association said it had concerns around the guidance for PPE use during aerosol-generating procedures because it did spread far enough in protecting all circumstances of aerosol generation.[48]

29. By the end of June, 44 Transport for London workers had lost their lives to COVID19. We asked representatives of health and social care staff organisations about the provision of PPE to non-healthcare key workers, such as taxi drivers, cleaners, transport, supermarket and security workers. The British Medical Association considered that these workers deserved to be protected and noted that failing to protect them led to more hospitalisations and increased the pressure on the NHS. The Department told us it would consider providing PPE to a wider group of people, such as key workers, as part of its pandemic planning if the evidence suggested that this would be effective. It also noted it had provided PPE guidance for some groups of workers, such as police and prison officers, during the first wave of the pandemic, and provided PPE to the Home Office and the Ministry of Justice.[49]

48 Qq 20–21, 26, 69, 73–75, 82; C&AG's Report *The supply of personal protective equipment (PPE) during the COVID-19 pandemic*, paras 17, 3.3–3.7, Figure 14

49 Qq 24, 79–80, 277–278

Formal minutes

Thursday 4 February 2021

Virtual meeting

Members present:

Meg Hillier, in the Chair

Shaun Bailey	Sir Bernard Jenkin
Sir Geoffrey Clifton-Brown	Nick Smith
Peter Grant	James Wild

Draft Report (*COVID-19: Government procurement and supply of Personal Protective Equipment*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 29 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Forty-second of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 8 February at 1:45pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Thursday 10 December 2020

Professor Martin Green, CEO, Care England; **Dr Chaand Nagpaul**, Chair, Council, British Medical Association (BMA); **Dr Emily McWhirter**, Retired Nurse, Royal College of Nursing; **Gavin Edwards**, Senior National Officer (Social Care), UNISON Q1–86

Monday 14 December 2020

David Williams, Second Permanent Secretary, Department of Health and Social Care; **Jonathan Marron**, Director General, PPE, Department of Health and Social Care; **Michael Brodie**, Interim Chief Executive, Public Health England; **Alex Chisholm**, Permanent Secretary, Cabinet Office; **Gareth Rhys Williams**, Government Chief Commercial Officer, Cabinet Office Q87–282

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

CGP numbers are generated by the evidence processing system and so may not be complete.

1 Association of British HealthTech Industries (CGP0001)

2 Association, The Healthcare Distribution (CGP0012)

3 BMA (British Medical Association) (CGP0019)

4 COVID-19 Review Observatory, Birmingham Law School, University of Birmingham (CGP0015)

5 Centre for the Study of Corruption, University of Sussex (CGP0014)

6 Clarke, Mr Ian (Associate Fellow, UKTPO) (CGP0004)

7 Clarke, Mr Ian (Associate Fellow, UKTPO) (CGP0005)

8 Frayne, James (CGP0011)

9 Local Government Association (LGA) (CGP0002)

10 Leonard Cheshire (CGP0020)

11 Murphy, Professor Peter (Professor of Public Policy and Management, Nottingham Business School, Nottingham Trent University) (CGP0006)

12 NHS Providers (CGP0003)

13 Public First (CGP0017)

14 Royal College of Nursing (CGP0007)

15 Royal College of Physicians of Edinburgh (CGP0013)

16 Szyszczak, Professor Erika (Fellow, UKTPO) (CGP0004)

17 Szyszczak, Professor Erika (Fellow, UKTPO) (CGP0005)

18 The Health and Care Professions Council (CGP0016)

19 Transparency International UK (CGP0018)

20 UK Anti-Corruption Coalition (CGP0021)

21 UKCloud (CGP0010)

22 Wakefield, Mr Jason (CGP0008)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

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Number	Title	Reference
1st	Support for children with special educational needs and disabilities	HC 85
2nd	Defence Nuclear Infrastructure	HC 86
3rd	High Speed 2: Spring 2020 Update	HC 84
4th	EU Exit: Get ready for Brexit Campaign	HC 131
5th	University technical colleges	HC 87
6th	Excess votes 2018–19	HC 243
7th	Gambling regulation: problem gambling and protecting vulnerable people	HC 134
8th	NHS capital expenditure and financial management	HC 344
9th	Water supply and demand management	HC 378
10th	Defence capability and the Equipment Plan	HC 247
11th	Local authority investment in commercial property	HC 312
12th	Management of tax reliefs	HC 379
13th	Whole of Government Response to COVID-19	HC 404
14th	Readying the NHS and social care for the COVID-19 peak	HC 405
15th	Improving the prison estate	HC 244
16th	Progress in remediating dangerous cladding	HC 406
17th	Immigration enforcement	HC 407
18th	NHS nursing workforce	HC 408
19th	Restoration and renewal of the Palace of Westminster	HC 549
20th	Tackling the tax gap	HC 650
21st	Government support for UK exporters	HC 679
22nd	Digital transformation in the NHS	HC 680
23rd	Delivering carrier strike	HC 684
24th	Selecting towns for the Towns Fund	HC 651
25th	Asylum accommodation and support transformation programme	HC 683
26th	Department of Work and Pensions Accounts 2019–20	HC 681
27th	Covid-19: Supply of ventilators	HC 685

Number	Title	Reference
28th	The Nuclear Decommissioning Authority's management of the Magnox contract	HC 653
29th	Whitehall preparations for EU Exit	HC 682
30th	The production and distribution of cash	HC 654
31st	Starter Homes	HC 88
32nd	Specialist Skills in the civil service	HC 686
33rd	Covid-19: Bounce Back Loan Scheme	HC 687
34th	Covid-19: Support for jobs	HC 920
35th	Improving Broadband	HC 688
36th	HMRC performance 2019–20	HC 690
37th	Whole of Government Accounts 2018–19	HC 655
38th	Managing colleges' financial sustainability	HC 692
39th	Lessons from major projects and programmes	HC 694
40th	Achieving government's long-term environmental goals	HC 927
41st	COVID 19: the free school meals voucher scheme	HC 689