Commons Committee of Public Accounts: COVID-19: Government procurement, and contracts for Personal Protective Equipment
Submission by NHS Providers, November 2020

NHS Providers is the membership organisation for the NHS hospital, mental health, community, and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £87bn of annual expenditure and employing more than one million staff.

Key messages

- The UK is now in a far more secure position in terms of PPE than it was in spring, with a more robust stockpile of items which were dangerously lacking in the initial peak of the pandemic. This will offer some reassurance to frontline workers as the NHS enters a second wave alongside winter pressures.
- However, it is essential that government and the national NHS bodies learn the lessons from the health and care sector's challenging experience at the start of the pandemic. While we understand that little was known about coronavirus at the start of the pandemic, the lack of preparedness, and the inadequacy of the national PPE stockpile, suggests the UK government and NHS bodies could respond more swiftly to learning and evidence from international experiences in future to better manage risk, secure the supply chain for different scenarios and plan the logistics of delivering stock to health and care settings. This will of course require sufficient funding for public health protection and disease control in the future.
- During the pandemic, trusts have retained responsibility for the health and safety of their staff and patients. However, they are reliant on the national supply system of PPE to fulfil those responsibilities and offer reassurances to their staff. Changes in guidance for the usage of PPE were helpfully clarified by Public Health England (PHE) and NHS England, based on the evolving scientific evidence, as the pandemic progressed but trusts tell us that this often undermined the confidence of frontline NHS staff in the equipment and approach.
- The lack of available data around national stock levels of PPE, coupled with the unpredictable nature of push deliveries and their contents, made it extremely difficult for trust leaders to plan ahead and deliver services. Trust leaders would feel reassured that PPE levels were secure at the point that the NHS returns to a 'pull' delivery system, rather than the emergency 'push' system.
- Although no acute trusts completely ran out of PPE at the peak of the pandemic, at times this was only narrowly avoided. It is also clear that the shortages of PPE were more extensive, serious, and difficult to overcome in other health and care settings (for example care homes), which had often never accessed national PPE supply systems before.
- The growth in the number of new domestic manufacturers of PPE provides an opportune moment to address issues raised by the fact PPE us manufactured to fit the average measurements of Caucasian males. This is unacceptable, and contributed to practical difficulties – and arguably the heightened risk – for some members of staff including those from Black, Asian and minority ethnic groups, and women.
- We would urge the government to track progress against the intentions set out in the PPE strategy.[1] We note that supplies and production are on track to meet important targets at the current time, with four months' worth of supply by the end of November and 70% domestic production by the end of the year.

[1] https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience

- The 'Make' initiative, led by Lord Deighton should be recognised as an important achievement by the businesses who have answered the call for domestic production of PPE. In order to secure this route of supply for the future, consideration must be given to ensuring the UK manufacturing industry can compete with the global market moving forwards.
- We would urge the government to track progress against the intentions set out in the PPE strategy and note that supplies and production are now on track to meet important targets with four months' worth of supply by the end of November and 70% domestic production by the end of the year. [2]

How PPE was supplied to NHS and social care organisations before the COVID-19 pandemic started

1. Prior to the outbreak of COVID-19, NHS trusts acquired PPE through a combination of national supply and independently procured contracts. Like every sector of the economy over the last decade, the NHS had been working to centralise the buying and distribution of its core supplies, significantly increasing efficiency. This central supply chain, with its predictable pattern of demand, has served NHS trusts well in normal times.
2. Whilst there are a manageable number of NHS trusts at just 217, there are upwards of 58,000 additional health and care settings in the UK. These settings – including care homes, community care providers, GP practices, and pharmacies – have always procured PPE from independent retailers rather than via national supply.
3. All procurement of PPE in the UK has been overwhelmingly reliant on importation from other countries. Supplying countries (e.g. China) provide PPE internationally, meaning that there was a sudden pinch point in demand when the pandemic hit globally. Efforts to increase national production of PPE will therefore be of enormous aid in the longevity of stable PPE supply in the UK and this must be a consideration in how the government seeks to manage the risk of a pandemic in the future.
4. PPE items have normally been used in trusts to meet relatively predictable patterns of demand in routine and urgent care – such as masks, gowns and gloves for surgical procedures, or gowns and gloves for phlebotomy. In addition to this procurement for business as usual, the UK had a national stockpile of PPE in preparation for the eventualities of an outbreak of pandemic influenza, and no-deal Brexit ,which was continually stocked (with the exception of gowns and visors which proved critical in the defence against COVID-19).[3] However, the logistics of delivering this stockpile to all health and care settings in the case of a pandemic had not been fully considered. As soon as the pandemic hit, with demand for certain items of PPE increasing by 5,000% overnight, the central supply chain that has traditionally been used to deliver PPE quickly became vulnerable.[4]

What government did, between the pandemic emerging in other countries and arriving in the UK, to prepare for the provision of PPE in the NHS and social care organisations

5. The Department of Health and Social Care (DHSC) stood up the National Supply Disruption Response (NSDR) on 13 March, six weeks after NHS England and NHS Improvement declared a Level 4 National Incident.[5] The NSDR was told to monitor PPE supply and provide resolutions to shortages where possible. It was available for healthcare settings to use from 16 March and followed previous plans which had been in place for repercussions from the UK's impending exit from the European Union. Healthcare settings were encouraged to "follow your usual mitigation procedures in the first instance to provide a resolution" to any issues with PPE.[6] The NSDR

[2] https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/922273/Coronavirus__COVID-19__-_personal_protective_equipment__PPE__plan.pdf p14

[4] https://nhsproviders.org/news-blogs/blogs/the-public-ppe-debate-is-in-danger-of-getting-stuck

[5] https://www.health.org.uk/news-and-comment/charts-and-infographics/covid-19-policy-tracker

system relied on pre-existing reporting mechanisms, and had its own call centre to be used in certain circumstances.[7]

6. Understandably, the government's plan was to draw down from the national pandemic stockpile and ensure stability of supply until additional PPE arrived in the country, in its required bulk. However, the stockpile was not configured for this particular pandemic. Visors and gowns were particularly lacking. While we understand the difficulties in seeking to predict future events, and the unknowns surrounding COVID-19 at the start of the pandemic, it will be important to examine why the pandemic stockpile was not configured for coronavirus and what could be done to better manage these risks in the future.
7. In addition, we understand that the practicalities of accessing large amounts of stock, very quickly, in confined warehouse space was extremely challenging – for example, the physical storage space of the national pandemic stockpile was too small to allow easy access for forklift trucks.
8. Whilst the 217 NHS trusts were overall served fairly well by the emergency processes which were put in place as outlined in paragraphs 11 to 19, there are over 58,000 additional health and care settings, including care homes, community care providers, GP practices, and pharmacies all of which required support. The logistical challenge of delivery to these settings – which are not 24-hour organisations and have always procured PPE from independent retailers rather than via national supply – was enormous. There were no pre-existing centralised processes for these settings, which is a key factor in why they were unable to access the NSDR in the same way that trusts were. The knock on effect which this had for trusts was enormous during the first peak, as the social care sector (including hospices, care homes and domiciliary care providers,) played a vital role in enabling hospitals to free up critical care capacity. Some trusts reported that care homes closed to new admissions, due to concern over treating COVID-19 positive residents, despite national guidance supporting this.[8] This hampered trusts' ability to allocate beds for seriously ill patients, causing a pinch point in service delivery. The logistics of delivering the national pandemic stockpile, including the ordering process for trusts and other settings, should therefore have been planned in detail before the pandemic arrived in the UK.
9. We also understand that there was initially some confusion as to the distinct responsibilities between the NHS Supply Chain, DHSC, and NHS England's central purchasing team. Largely due to the NSDR's reliance on pre-existing mechanisms, all were involved, and the central stockpile became something of a separate entity to proceedings as it was unclear who was responsible for different elements of different processes in PPE procurement and delivery. While colleagues in the national bodies have worked hard to rectify any confusion and create a process which now works relatively smoothly, it is possible that clarification of responsibilities for procurement and the 'push' process could have been in place earlier as part of a clearer approach to managing the potential risk posed by a pandemic.
10. It is worth noting that Michael Wilson, Chief Executive of Surrey and Sussex Healthcare NHS Trust, and Joe Harrison, Chief Executive of Milton Keynes University Hospital NHS Foundation Trust, were brought in to support NHS England and NHS Improvement in their work on national PPE availability and guidance. Their expertise was brought to bear at a critical juncture for national PPE supply, and other trust leaders found their insights and work invaluable in this area particularly in facilitating communications between trusts and colleagues in the national teams.

How government responded when problems arose in the supply of PPE

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[6] https://nhsprocurement.org.uk/covid-19-contingency-planning-national-supply-disruption-response/
[7] https://nhsprocurement.org.uk/covid-19-contingency-planning-national-supply-disruption-response/
[8] https://nhsproviders.org/media/689480/nhs-providers-briefing-spotlight-onthe-supply-of-personal-protective-equipment.pdf

11. When it became apparent that distribution of the national pandemic stockpile was neither reliable nor fast enough, government rapidly mobilised the army and the UK national logistics industry, moving to a 'just in time' distribution method.[9] An emergency 'push' distribution system was put in place and began daily deliveries on 10 April, to proactively deliver pallets of PPE (rather than specifically requested items) from the stockpile to trusts.[10] This push system was in action faster than anticipated and worked fairly well for most items. However, the system did not remove the short to medium term risks to PPE supply.
12. In the early stages of the pandemic, there remained particular shortages of face visors, (though this was relatively easily rectified with local production and careful reuse,) and high-end gowns. Only one manufacturer in the UK had access to fully fluid-repellent material, required for gowns, at the peak of the pandemic. Whilst companies such as Burberry could manufacture gowns, they were not always made from the correct material. This issue took a significant amount of time to rectify, leading to some operations being postponed at short notice when organisations ran out of gowns. As of June 2020, ongoing insecurity of PPE supplies coupled with guidance that all staff in NHS trusts must wear masks at all times, left trusts unable to plan with confidence the volume of care they would be able to carry out. [11]
13. In April, Public Health England approved the use of coveralls in place of gowns,[12] as well as reuse of certain items of PPE in cases of extreme shortages.[13] Trust leaders welcomed clarification from the national bodies on guidance for the use of PPE which was based on scientific advice, but were concerned about how best to reassure their staff that newly revised guidance was evidence based. Changes in guidance on PPE usage often damaged the confidence of frontline staff.
14. The push system also meant that trusts received up to five different brands of face mask in any given delivery. In the early weeks of the pandemic, the allocation of 'usual' items, or a consistent single brand of FFP3 mask, to each trust would have saved valuable time on the frontline by avoiding the need for repeated fit testing when different types of masks arrived. Fit testing can take up to an hour per person, and shortages of mask fit testing liquid exacerbated this situation (though this situation rapidly improved as all fit test fluid quickly moved to UK-based manufacture).
15. The modelling used to inform decisions about which items of PPE trusts would receive via push delivery in the initial stages of the pandemic did appear to be problematic. The unpredictable timings and contents of deliveries, as well as the lack of differentiation between sizes of trusts, caused some issues – particularly reducing trusts' ability to plan services and reassure staff. In mid-April, several trust chief executives told NHS Providers that they were only able to plan PPE usage in their organisations 'day by day, hour by hour' due to limited supplies. One trust ran down to just 24 hours' supply of face masks, and another CEO reported red flagging their limited gown stock via the NSDR but not then being included in that week's list for delivery. There were also reports of push deliveries which did not arrive and were not subsequently rescheduled. However, trusts recognised the pressure which the national supply chain was under and shared stock between organisations to the best of their ability, due to the extraordinary circumstances. This meant that trusts avoided complete shortages in items, though the situation was incredibly narrowly avoided.

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[9] https://www.nao.org.uk/wp-content/uploads/2020/06/Readying-the-NHS-and-adult-social-care-in-England-for-COVID-19.pdf

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/922273/Coronavirus__COVID-19__-_personal_protective_equipment__PPE__plan.pdf

[11] https://nhsproviders.org/recovery-position-what-next-for-the-nhs/key-points

[12] https://www.england.nhs.uk/coronavirus/publication/approval-by-health-and-safety-executive-for-use-of-coveralls-as-an-alternative-option-for-non-surgical-gowns/

[13] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe

16. Procurement of PPE was made more complex at the peak of the pandemic in England due to processes being conducted via intermediaries, particularly in the Chinese market. This meant that on repeated occasions, agreements which the UK believed to be final were, in fact, not.
17. The 'Make' initiative, led by Lord Deighton, appears to have been successful in increasing UK-based manufacture of PPE, and therefore the sustainability of supply. In September, DHSC published a PPE strategy which stated that four months' worth of supply of all items (excluding gloves) is expected by November, and 70% of all the UK's PPE will be in domestic production by the end of the year. [14] This should be recognised as an important achievement by the businesses who have answered the call for domestic production of PPE. In order to secure this route of supply for the future, consideration must be given to production cost in order to ensure that the UK manufacturing industry can compete with the global market moving forwards.
18. In the PPE strategy, DHSC has committed to listen and respond to the practical difficulties faced by Black, Asian and minority ethnic staff and women in using PPE.[15] There is now a key opportunity to address the underlying issue that PPE is manufactured to fit the average measurements of Caucasian males, given the growth in the number of new domestic manufacturers.
19. The planned provision of PPE to social and primary care settings, in DHSC's September PPE Strategy, was also a vast improvement and much needed.

The scale of problems in the availability of PPE throughout the emergency

20. NHS trusts have a responsibility to keep their staff, and patients safe and to manage risk, which all trust boards take very seriously. During the pandemic, all trusts were put in the difficult position of retaining those responsibilities as employers and service providers while being fully dependent on the national supply system for PPE.
21. No acute trusts completely ran out of PPE, though this was only narrowly avoided (as detailed in paragraph 15). The supply of gowns was the most pertinent problem in PPE supply for trusts over several months (as detailed in paragraph 12). Trust leadership teams and their staff were both resourceful and innovative in solving some of the issues they faced – for example, finance teams in several trusts approached local vets and other private companies to source appropriate coverings for staff. Visors were also a particular area of shortfall in NHS trusts, but rapid development of cottage industry visors production resolved this relatively quickly.
22. At different times during the months from March to May, IIR masks were also in short supply, resolved when an overdue shipment arrived. FFP3 masks were initially an issue due to different brands having different fits, requiring trusts to repeat fit-testing processes for each brand. This is sometimes described as a shortage, but in reality, reflects the inconsistent allocation of brands to trusts because of the nature of push deliveries.
23. There was significant media publicity around some medical staff being concerned about their access to PPE. When these claims were probed, it was often the case that staff felt the guidance was insufficient, rather than them not being provided with the advised amount of PPE by their employer. (As detailed in paragraph 13.)
24. Whilst acute trusts experienced some shortfalls, but never ran out, of PPE, the picture was starkly different in other health and care settings. There were consistent reports of care homes, community care providers, GP practices, and other settings having no access to PPE supplies.

[14] https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience

[15] https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience

This was partly because they were not part of the formal NHS supply chain and received their PPE from commercial suppliers. National bodies recognised the challenges of delivering to over 58,000 settings (compared to just 217 trusts) and responded by setting up emergency 'push' deliveries and an emergency telephone ordering line. This did not work to the extent needed, and providers of NHS community services expressed their frustration that their organisations were 'not a priority' for national distribution of PPE despite providing essential care for newly discharged patients.[16] The social care sector, including hospices, care homes and domiciliary care providers, played a vital role in enabling hospitals to free up critical care capacity for the most seriously ill. Some trusts reported that care homes closed to new admissions during the first peak, due to concern over treating COVID-19 positive residents, despite national guidance supporting this.[17] Social care providers were under increased pressure, with 92 care homes reporting COVID-19 outbreaks in a single day and 13.5% of all care homes reporting COVID-19 positive residents as of 13 April (although anecdotally this rose to two-thirds).[18] It is clear that the shortages of PPE were more extensive, serious and difficult to overcome in these settings. Whilst there were reasons for this – primarily due to these settings having never accessed national PPE supply systems before – it was an egregious failing.

25. Looking ahead, a secure and reliable supply of PPE remains vital for the NHS to continue to restore all services and to treat those patients with coronavirus. Trust leaders have said that the biggest risk to NHS service delivery is the 'perfect storm' of workforce shortages, staff burnout, second wave of coronavirus and a potentially difficult winter.[19] It will be important for the government to track progress against the intentions set out in the PPE strategy[20] and to learn the lessons from the first weeks and months of the pandemic to manage similar risks in the future.

[16] https://nhsproviders.org/media/689480/nhs-providers-briefing-spotlight-onthe-supply-of-personal-protective-equipment.pdf
[17] https://nhsproviders.org/media/689480/nhs-providers-briefing-spotlight-onthe-supply-of-personal-protective-equipment.pdf
[18] Professor Chris Whitty, Chief Medical Adviser, government daily coronavirus press conference, 13 April 2020 https://www.youtube.com/watch?v=tWORpOSnmBA&list=PL5A4nPQbUF8Ck7csEOg98U0-bA970noXS
[19] https://nhsproviders.org/the-state-of-the-nhs-provider-sector-2020/key-findings
[20] https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience