Why did so many thousands die unnecessarily?

Report of the People's Covid Inquiry

December 2021

7. PROFITEERING FROM THE PEOPLE'S HEALTH

Inquiry Session 7

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

7.0 INTRODUCTION

7.0.1 The UK should have started from a position of strength in facing the national emergency and the global pandemic. Its publicly provided National Health Service is world-renowned and its research and policy in public health has had a similar reputation. Possibly influenced by this, the Global Health Security (GHS) Index had assessed the UK and the USA as having the best plans in the world to respond to capability to prevent, detect, and respond to infectious disease threats.[7.1] The reality could not have been further from the truth: UK death rates and impact on the UK economy were amongst the worst of the advanced economies and inequalities have been laid bare.

7.0.2 The Inquiry heard how a series of policy decisions had turned world-leading pandemic planning on paper into one of the world's starkest failures. The contrast between the need for the nation to pull together and to rely on its public resources on the one hand and, on the other, the policy decisions of Government is breath-taking. Witnesses in this and previous sessions testified to Government decisions to deliberately bypass the UK's public services and local authorities and to contract out Covid-related services to private companies, too many of which had neither a track record with the health service nor of cooperating with other sectors on a mass scale. Effectively, the Government was ignoring, and did not even consult, experts in public health and general practice with strong local connections, intensive care, infection control and NHS procurement and 700,000 volunteers.

7.0.3 It is ill-judged and irresponsible of the UK Government to have allowed its ideological loyalty to the private sector and its mistrust of publicly funded services, pre- and during the pandemic, to have determined its policy decisions.

7.0.4 Witnesses at the Inquiry testified to the devastating impact of the policies on every major area of service planning and decision-making:

- The pre-pandemic running down of public health, the NHS and social care
- Procurement policies pre-pandemic which had fragmented a previously effective national network and, coupled with neglect of the outcome of pandemic planning exercises, led to unproductive emergency procurement of thousands of ventilators and the deeply flawed sourcing of PPE
- Decisions to outsource Covid services and capacity building, included the COVID-19 Clinical Assessment Service (part of NHS 111); laboratory capacity (Lighthouse labs); private hospital contracts; diagnostic testing; testing and contact tracing; the failed early prototype contact tracing app; and even the food voucher system for school children
- Expenditure on private consultancies, for example, on 'test and trace' services and the development of 'vision, purpose and narrative' for the National Institute for Health Protection, newly created mid-pandemic – now renamed the UK Health Security Agency (UKHSA)

7.0.5 The one notable success – in vaccine development and procurement – was a partnership between the publicly funded university research teams and Pharma, notably the Oxford University collaboration with AstraZeneca plc, and delivered with dramatic success by the NHS.

7.0.6 Our Inquiry heard testimony that there were well-established service provision and supply routes readily available – from publicly provided services (GPs, local government, NHS and university labs), established public procurement routes (ventilator manufacturers supplying the NHS) and offers from businesses to divert their work into PPE production. These were bypassed and ignored, with serious consequences.

7.0.7 The impact of pre-pandemic outsourcing of procurement contracts distributed by NHS Supply Chain failed spectacularly. The massive expenditure on outsourcing and privatisation to create 'NHS Test and Trace' has been a notorious failure. The poor quality of private contracts during the pandemic inevitably may have contributed to a wholly inadequate response to coronavirus, placing staff in the NHS and care sectors and the general public in avoidable danger.

7.0.8 The National Audit Office (NAO) reported that public contract funding has been differentially awarded to Conservative Party donors and close contacts.[7.2] Profits for shareholders have benefited spectacularly, particularly on the outsourcing of NHS Test and Trace.[7.3] There have been successful legal challenges on behalf of the taxpayer in relation to Covid contracts – one important example being the successful challenge on the Palantir contract (see para 7.12).

The Inquiry heard from staff, patients and family members who have been directly affected by decisions to outsource clinical and support services contracts.

7.1 PRIVATISATION AND OUTSOURCING

Pre-pandemic policy on the NHS and social care continued into the pandemic

7.1.1 In the years prior to the pandemic, the opening up of NHS services to contracts with the private sector had been the dominant Government strategy. The Inquiry heard in Session 1 about the negative impact on health and social care of Government policies broadly hostile to public expenditure funding publicly provided services, particularly since 2010. The combined impact of underfunding, marketisation and competitive contracting had left public services ill-prepared for the pandemic and for their role in protecting those at greatest risk. Now the policy escalated dramatically during Covid, with the usual tendering process and competition guidelines set aside under emergency coronavirus legislation. The major plank in Government pandemic policy has been, and remains, to build a parallel outsourced service, bypassing public resources.

Impact of a marketised health system on costs and efficiency

7.1.2 Counter to the assertion that competition would drive up efficiency and cost-effectiveness, the Inquiry heard in Session 1 that the opposite was the case:

> *'Before the market system ... about 6-7% of NHS spending was effectively on administration and management overheads. ... [In a] fully marketised system, the level of that spending is upwards of 20%. ... We're somewhere in the middle – not a fully marketised, fully privatised system. But ... we've*

introduced a lot of the overheads and the complications that run along with them, but without bringing the funding in.' (Lister)

7.1.3 Social care and mental health have been particularly affected by privatisation. Lister explained that, with the Thatcher reforms, social care was effectively privatised from 1993. Private nursing homes largely took over responsibility for residential care. With the current state of care in the community, unless you have the most extreme level of need, you will not receive support from local authorities. Effectively, people who have medium or low levels of need and who could previously have been supported to live in their homes through funded resources, are now getting nothing until they actually reach crisis point. Over a million are not getting social care or support. 1.6 million are without the mental health support they need.[7.4]

7.1.4 Models of mental health care have radically changed and to a large extent continue to move away from hospital-based care. Numbers of hospital beds have been slashed[7.5] and today much of the NHS hospital mental health inpatient capacity has been replaced by private beds, at greater cost:

'Those NHS hospital beds were effectively … replaced by increased dependence on private hospital beds, quite often a long distance away from where people actually needed the treatment. This is not part of an improvement in services. This was part of an actual decline and mental health remained under massive pressure long before the Covid epidemic has now piled massive increased pressure on all fronts in terms of mental health.' (Lister)

7.1.5 Professor of Global Health Medicine David McCoy, speaking on behalf of the Centre for Health and the Public Interest (CHPI) in Session 7, had studied worldwide evidence on how private care can destabilise health systems:

'If you get the public and the private interface wrong, you end up with a system like you have in the USA, where you have a health system that is both extremely expensive, not cost effective at a population level, and extremely inequitable. And the direction of travel that we have in the NHS is very much towards that kind of public/private model that we have in the United States.'

7.1.6 In his opinion it is possible for advocates of private involvement in health services to 'cherry-pick certain indicators and give the impression that there are improvements', but looking at health at a population-wide level, at equity and efficiency, covering all elements of health care, 'then yes, without question in my mind we are going down the route of a flawed health policy'.

7.1.7 McCoy said that there were many MPs and members of the Lords who held stakes in the private hospital sector, and that conflicts of interest should concern everybody. He considered current legislative proposals to be a cause for concern: they include the establishment of Integrated Care Systems, where the private sector may be invited into the decision-making process of how public funds will be used and distributed within the health system, together with a lack of adequate regulation. (Since the end of the inquiry, Owen Paterson MP has resigned after lobbying for Randox and other companies, in a paid role. Randox is one of the beneficiaries of the Test and Trace programme [see para 7.1.9]).

Policy choices and consequences

7.1.8 The Government has stated that contracting with private companies has been an essential component of its pandemic response. The Inquiry heard several examples of what became of these initiatives and what is known about the companies who got the contracts. This was not 'value for money'. Under the cover of the emergency, the Government has awarded £18bn in coronavirus-related contracts during the first six months of the pandemic, most with no competitive tendering processes.

7.1.9 The £22bn NHS Test and Trace budget had been expanded to £37bn by the second year and is larger than funding for the police and fire services combined, with multimillion pound contracts handed to private companies big and small. The failed NHS contact tracing app cost the taxpayer £11.8m. Randox Healthcare was paid £133m for test kits that were later withdrawn as faulty. They remain a major player in SARS-CoV-2 test processing. Key aspects of their practice have been severely criticised.[7.6 7.7]

7.1.10 During the course of the Inquiry, beneficiaries of contracts worth £1.5 billion were identified by the NAO to be contacts of ministers and conservative MPs. (They included personal friends, neighbours, party supporters or donors.) The NAO was highly critical of this.[7.8] (See also 'Governance failures' para 7.11.3) The Public Accounts Committee reported that they could find no evidence that the NHS Test and Trace investment had made any impact on the spread of the virus. [7.9]

Use of consultancies

7.1.11 Part and parcel of the reliance on the private sector is the expense and profit-taking margins involved. Famously the outsourced NHS Test and Trace service was paying Deloitte £900,000 per day for its 1000 consultants at an average close to £1000, and for some as much as £6-7000, per day.[7.10] Mid-pandemic, the Government chose to reorganise its public health administration, employing management consultants McKinsey at a cost of £563,000 for advising on the 'vision, purpose and narrative' of the National Institute for Health Protection (now renamed the UK Health Security Agency[7.11]).

7.2 HOSPITAL CAPACITY AND CONTRACTING WITH PRIVATE HOSPITAL SECTOR

7.2.1 The impact of past policy of stripping back public sector capacity (in public health, NHS hospital capacity, primary, mental health and community services) led to a rushed and ill-thought-out decision to purchase private hospital capacity en bloc that in the end was grossly underused. Over the 10 years prior to the pandemic, the NHS acute hospital sector had been cut back to a dangerous level of reduced capacity. The UK has one third of the number of beds per head of population compared to Germany (Wrigley), the impact of historic policy:

> *'The NHS has over the past few decades seen a reduction in its bed capacity, to the point where England has one of the lowest beds-to-patient population ratios in Europe. And this has been partly a deliberate strategy to reduce that reliance on NHS hospital beds. I would say it's part of a strategy to create room*

and opportunities for the private sector to develop in the hospital sector. So, we entered the pandemic with a lack of hospital capacity.' (David McCoy)

7.2.2 With the alarming situation unfolding in Italy in February and March 2020, the Government faced the shortfall in capacity in hospital beds and ITU ventilators and staff with some panic. However, rather than seeking ways urgently to build NHS capacity, it turned to the private hospital sector with a huge block contract in March 2020, renewed for four years in a £10 billion deal from April 2021. This left the NHS without the investment to build its capacity and long-term resilience it so badly needed.

7.2.3 The Inquiry heard that Government policy choices during the pandemic were based on attitudes to public services that appeared to be ideological. After years of Government denial that privatisation was core policy, the Secretary of State for Health and Social Care was confident to change this defensive stance and to publicly announce to Parliament mid-pandemic the policy of bringing in the private sector to 'partner' the NHS:

'The independent sector has played a critical role in helping us get through the crisis and will play a critical role in future ... That has put to bed any lingering, outdated arguments about a split between public and private in healthcare. We could not have got through the crisis without the combined teamwork of the public and private sectors.' (Matt Hancock, Commons 2 June 2020[7.12])

7.2.4 McCoy gave evidence from the CHPI's research examining the contract between Government and the private hospital sector during the pandemic and the financial issues connected with it (published October 202[1][7.13]). The March 2020 contract was set up by the Government with 26 companies in the private hospital sector to block book their entire capacity of 8000 beds. This was done ostensibly to help the NHS manage the Covid epidemic, but in return, the NHS would cover all the operating costs of the private hospital companies. McCoy said that there could have been an argument to bring in capacity urgently, but the question was whether this was a good deal. The CHPI data suggests that it was not.

7.2.5 Private hospitals had been facing 'real jeopardy' with the Covid pandemic, said Dr McCoy, and were seeing a decline in demand from privately funded patients: 'This deal really helped to keep those private hospitals afloat.'

7.2.6 In the initial period of the contract, March-August 2020, the private sector's 8000 beds would be made available to the NHS and a stated number of doctors, nurses and other clinical workers. It is not known exactly how much was paid, nor about the large amount of capacity that wasn't used to deal with the pandemic. The private sector capacity was underused, but the Government was paying for the entire capacity, at the full running cost of those private hospitals – all the operating costs, including rent, interest payments and staffing to the private hospital groups.

7.2.7 Capacity was probably used for diagnostics and non-elective procedures, not patients with Covid. The CHPI has data for 187 private hospitals out of 193 with overnight beds. They have estimated that on average there was one Covid patient per day in the private hospital sector, and probably at peak there may have been at most something like 67 patients.

7.2.8 On 39% of the days from March 2020 to March 2021 no bed was occupied by

a Covid patient, and on 20% more days, only one bed was occupied by a Covid patient. In total, the 187 private hospitals accounted for 0.08% of the national total of 3.6 million Covid bed-days. And for non-Covid work, by their estimate, less NHS-funded health care was provided in the private hospital sector than in 2019.

7.2.9 Estimates of the cost of those contracts – details are not in the public domain – are between £200m and £500m per month.[7.14.] Government estimates are that the contract cost £2 billion between March 2020 and March 2021. The CHPI thinks it is closer to double that amount.

7.2.10 From April 2020 onwards, private hospitals were allowed to continue to provide care to privately funded patients and the income from that privately funded healthcare was paid back to the Government. Essentially this meant

> *'During this period of time, the private hospital sector was able to continue with providing private health care to privately financed patients at a time when the NHS was obviously being challenged by the Covid-19 pandemic itself.'* (McCoy)

National Increasing Capacity Framework

7.2.11 As the initial contract neared the end, the Government created a four-year £10 billion funding programme – the National Increasing Capacity Framework – which aims to allocate approximately £2.5 billion a year to the private hospital sector, covering 90 approved suppliers (including smaller providers – optometrists, cosmetic surgeons and sole-specialist clinics) and costing about double the amount of NHS funded care provided in the private sector in 2018, and 2019 – a big investment not in the NHS but in the private sector to deal with the growing waiting lists.

7.2.12 Not only did the private sector have all its running costs underwritten during the first pandemic year, but forward-looking, there is a guaranteed continuous stream of public funding going into the private hospital sector to meet unmet NHS demand for semi-urgent and elective care that has built up during the pandemic.

7.2.13 There is rising demand for private sector healthcare as those with the means to pay privately will do so to avoid growing NHS waiting lists, 5.7 million in October.[7.15] In the main, it will be NHS staff working sessions in the private sector operating on NHS patients.

7.2.14 Prior to the pandemic, something like 18% of NHS funding was being directed towards the private sector[7.16] (excluding GPs as independent contractors). Inevitably this will rise and the failure to invest in NHS capacity will have structural effects on the health system as a whole. It heightens problems around the creation of a two-tier system and for some segments of society, a decreasing commitment to the NHS as a public service based on the principle of universal access at its centre.

7.2.15 When asked whether the same people in Government were going to repeat the same mistakes, David McCoy questioned whether these Government decisions were mistakes or whether they were really part of commitment to a privatisation of the health system. And he warned:

> *'This will essentially erode some of the fundamental principles of the NHS, which is a publicly funded and publicly provided service across the board ... which will*

result in inefficiencies in the delivery of health care at a population level.'

7.2.16 The CHPI's report recommends that the Department of Health and Social Care answer the following questions:

- Exactly how much was spent by the NHS on purchasing services from private hospitals during the first year of the pandemic, and what did the NHS receive in return?
- Why were the private hospitals allowed to continue performing non-urgent elective care when the NHS was under the greatest strain, and why was the amount of purchased capacity reduced before the widely predicted second wave of the pandemic?
- To what extent did the contract protect the interests of the private hospital companies rather than those of the NHS?

7.2.17 McCoy explained how the private sector has virtually no clinical staff and relies on NHS staff working private sessions. In order to maximise profit margins, the sector usually refuses to offer clinical training whilst reducing training opportunities for NHS staff to be involved in the elective NHS work transferred over to the private hospitals.

7.2.18 Dr Wrigley reinforced how there were negative consequences of the increasing use of private hospitals. Commenting on the Government contract with the private hospital sector, extended by four-years and £10 billion, this could have a devastating effect on training of doctors, nurses and health staff. All junior doctors receive their training from their peers and their seniors, all within the bounds of providing day-to-day care. Private hospitals have no willingness to take on training because it might slow procedures down, not as many patients would be going through the theatres or outpatient clinics. The less complex patients, who could be useful for training for surgeons and others, are going through the private hospitals, and trainees would lose that vital time and experience that they need to learn how to do procedures.

7.3 PRIVATISATION OF PROCUREMENT PRE-PANDEMIC

7.3.1 The history behind the evident failings of the procurement supply chain from the start of the pandemic is outlined in the report co-authored by Inquiry witness John Lister and campaign group, We Own It.[7.17] Procurement and supply were privatised well in advance of the pandemic.

7.3.2 Important background to the Inquiry evidence is the history of the NHS Logistics Authority, set up in 2000 as an NHS Special Health Authority. Providing 'considerable value to the NHS', it was 'market tested' for outsourcing to the private sector and was dissolved in March 2006. Its functions were transferred to NHS Business Services Authority in preparation for being contracted out (NHS Logistics Authority Annual Report 2005-06). NHS Logistics Authority was replaced by NHS Supply Chain in 2018 after years of pursuing a policy of outsourcing.[7.18] The overall strategy was the 'just-in-time' approach dominant in commerce and industry, aimed at minimising costs. NHS Supply Chain is technically a part of the NHS, headed by the Secretary of State. But this is an umbrella for a complex web of contracts with private companies. Immediately upon its formation NHS Supply Chain outsourced two major contracts for IT and logistics, and then broke up and outsourced the whole

procurement system, by delegating eleven supply areas to various contractors. DHL was put in charge of finding wholesalers to supply ward-based consumables, including PPE kits. Unipart was given control over supply chain logistics, including the delivery of PPE. The rationale for this drive towards greater outsourcing and greater fragmentation was 'efficiency savings'.

7.3.3 'Just-in-time' procurement has been shown to be fundamentally unsuitable for public health planning. Pandemic exercise planning highlighted the high risk of running out of PPE and other essential equipment early in a pandemic (see report section 1.4 and paras 7.7.2 and 7.7.5).

7.3.4 Under the NHS pandemic influenza preparedness programme (PIPP), pharma distribution firm Movianto was responsible for maintaining a stockpile of PPE. However, within days of the pandemic spreading in the UK, it became evident that there were serious supply problems of vital PPE. Adequate life-saving supplies simply were not available for frontline NHS staff, let alone for other frontline work in care homes, community services, for school and transport staff. In financial trouble, Movianto, the European arm of US Owens & Minor, was sold in June 2020 to a French healthcare logistics firm EHDH.[7.19]

7.4 OUTSOURCING OF THE NHS 111 COVID-19 CLINICAL ASSESSMENT SERVICE

7.4.1 The NHS 111 advice service was rapidly expanded by creating the COVID-19 Clinical Assessment Service (CCAS). The Government outsourced the recruitment of staff and running of the service to the private sector.[7.20 7.21] In Sessions 1 and 2, a GP and two members of Bereaved Families for Justice have spoken of the impact of making the outsourced Covid triage, part of NHS 111 (see report sections 1.1 & 2.7). The majority of staff were non-clinical and poorly trained call handlers, the first point of contact for coronavirus enquiries, testing and contact tracing.

7.4.2 The Inquiry heard the impact of cursory training and life-critical decision-making algorithms in non-clinical or inexperienced hands:

> *'Really early on, one of the key patterns that was emerging was of people who clearly needed hospital treatment but were told to stay at home by the 111 service ... despite having really severe other symptoms that [you imagine] at any other time would have resulted in them going to hospital.'* (Goodman)

7.4.3 Lobby Akinnola gave poignant testimony about his father:

> *'My dad got ill at home, and ... over the course of the next two just over two weeks, he was at home kind of deteriorating. And during that period, he was calling the 111 help service and also spoke to his GP [on the phone] and to just get advice on what he should be doing and whether or not he needed to go to hospital. And he was advised to stay at home and ... when they thought he might have a lung infection ... they sent him some antibiotics but unfortunately, he then died shortly after receiving the antibiotics and passed away at home. My dad ... was at home throughout the entire period of time.'*

7.4.4 One important question for a future public inquiry is whether outsourcing this critical triage service to private companies using largely untrained, non-clinical staff, and triage failing to apply NHS and professional clinical and safety standards,

contributed to the avoidable deaths of people like Akinnola's father.

7.5 PRIVATISING PUBLIC HEALTH TESTING AND CONTACT TRACING

7.5.1 Previous Inquiry sessions heard of the horror of public health specialists and clinicians at the failure of the Government to mount any effective system for case finding, testing and tracing of contacts, and isolation with support (FTTIS).

7.5.2 Dr Wrigley told the Inquiry that the Public Health system had been 'eviscerated' following disinvestment and restructuring over the last 10 years. The 2012 Health and Social Care Act had promised that Public Health would have a ring-fenced budget, embedded in local government, but the budgets had 'just disappeared'. Though the enfeebled state of public health was of Government making, it provided the cover and rationale to turn to the private sector for Test and Trace at the start of the pandemic.[7.22]

7.5.3 The regular reports of tragic and calamitous failure of the process loomed as a spectre behind the grandiose daily claims of Secretary of State for Health Matt Hancock, and the Government, who tried to avoid criticisms of current failure by setting ever higher targets for future test capacity, future targets for numbers of people who would be traced and told to isolate.

7.5.6 The pandemic demanded an urgent development of testing, test equipment, processing and communication of results and essential part of the FTTIS public health approach. The Inquiry heard that public services with clinical knowledge, and companies with expertise already working with the NHS and with significant capacity were available to step up on testing and tracing. The UK's local public health, primary care, university and hospital services were waiting. Government support and investment could have been used to transform them into the national integrated network that the pandemic demanded. Instead, the Government bypassed 44 existing NHS labs and employed private sector firms such as Deloitte, Serco and Sitel to set up the privately-run 'NHS Test and Trace' with poorly coordinated, often remote, parallel testing sites without, for far too long, automatic reporting of results to GPs or local public health. And to process the SARS-CoV-2 tests, they set up the Lighthouse laboratories through private sector and private-public partnership contracts (see report section 7.6).

7.5.7 The BMA has long-opposed deepening privatisation and outsourcing in the NHS. Now it had significant concerns about the substandard performance of the Test and Trace system. Contracts for £37 billion have been awarded to private companies to run the misleadingly named 'NHS Test and Trace' service over the two years, described by the Public Accounts Committee as 'unimaginable costs' with no evidence of good outcome:[7.23 7.24]

> *'There is no clear evidence to judge NHS Test and Trace's overall effectiveness. It is unclear whether its specific contribution to reducing infection levels … has justified its cost.'*

The scale of the expenditure was justified by the Government as the way to avoid a second lockdown. The plan failed to avoid two further lockdowns and 100,000 further deaths.

7.5.8 Wrigley added to what Salisbury had said in Session 2 (see report section 2.6): GPs had major concerns for patients trying to access Test and Trace: sometimes

they had to travel hundreds of miles to get a test, including driving on motorways when they were unwell – and test results were often delayed. And for many months there was no process to communicate test results to patients' GPs.

7.5.9 The privately contracted app development to aid contact tracing by alerting people when they had been in proximity to a person infected with coronavirus was also an expensive failure. Public confidence was lost when there were serious questions of data-confidentiality and effectiveness. The failure of the pilot on the Isle of Wight led to the app's demise. Meanwhile other countries developed more effective apps, with greater data protection accompanied by greater public confidence. The cost of the failed project was over £10m. A radically revised NHS app was finally launched in September 2020 at the aggregate cost of over £35m.[7.26]

7.5.10 Dr Wrigley told the Inquiry that the companies involved in the 'NHS Test and Trace' service such as Serco and Sitel had no experience about how to run services. In one instance Serco had subcontracted to a company called Hays Travel where staff had had one day's training or less. This had caused huge concern for doctors. One Hays Travel staff member who worked on a Covid phone line stated: 'We're not medically trained. I believe members of the public believed they were ringing medically trained people.'[7.27]

7.5.11 Wrigley pointed to the sharp contrast where NHS GPs and their teams have been fantastic in delivering the coronavirus vaccine campaigns. The Government had to be given their due for ordering enough vaccines in good time, but

> *'We do [a national vaccine rollout] every year with flu campaigns. We know our population, we know our patients, our patients trust us. So, we were absolutely in the best place to do that. It really does frustrate me when the Government or the Cabinet try and take credit for the vaccine campaign, when actually it's the NHS. It's all the staff in surgeries, hospitals and centres that have delivered vaccines, plus all the volunteers. And we must celebrate the achievements of the NHS in that.'*

7.5.12 Wrigley told the inquiry that the BMA had published documents asking for a larger proportion of the national budget for Track and Trace to be allocated to local Public Health teams to allow integration between testing being delivered at scale and contact tracing led by Public Health doctors on the ground who know their area and know their patients, but these pleas had been ignored.

7.5.13 Postscript: The Public Accounts Committee of the House of Commons followed up their critical report of February 2021[7.23] with a further report, finding that there had been some improvements, for example in the cooperation between the UK Health Security Agency and local authorities' Public Health teams, but that NHS Test and Trace Service is

> *'... one of the most expensive health programmes delivered in the pandemic, allocated with an eye-watering £37bn over two years, although it underspent by £8.7 billion in its first year ... but its outcomes have been muddled ... professed aims ... overstated or not achieved. For the vast sums of money set aside for the programme, equal to nearly 20% of the 2020–21 NHS England budget, we need to see a proper long-term strategy and legacy as it moves into the new UK Health Security Agency .'*[7.25]

We return to this in our findings and recommendations (see report section 7.13)

7.6 PRIVATE PATHOLOGY LABORATORIES

7.6.1 As stated earlier (see report section 7.5), 'NHS Test and Trace' run privately by Serco, Sitel and others, placed testing and contact tracing outside of the NHS. Alongside this, the Government decided early in 2020 to bypass NHS, public health and university laboratory capacity. They set up the parallel network of private or private-public partnership mega-labs named 'Lighthouse laboratories'. Five Lighthouse laboratories were established in Milton Keynes, Alderley Park, Glasgow, Cambridge and Newport alongside a contract with Randox for Northern Ireland. Additional sites are planned for Charnwood, Newcastle, Brant's Bridge and Plymouth. Leamington and a site in Scotland were announced in November 2020. The Inquiry heard evidence critical of these decisions and their outcomes.

7.6.2 The critically needed nationally integrated process referred to above – to coordinate the finding and testing of patients, communicating results quickly to GPs and local public health teams and to enable the tracing of contacts – was never established. Private contracting of parts of the process dislocated what should have been a seamless chain. The inquiry heard from Dr Salisbury (see report section 2.6) that test results were not reported to GPs routinely for several months – this basic requirement had not been in the contract:

> *'The Government has set up a growing network of Lighthouse Labs in partnership with a variety of suppliers including NHS Trusts, commercial suppliers, and not-for-profit organisations, in order to process test samples from an entirely new network of testing sites.*[7.28]

7.6.3 The laboratories will have investment for technology for automation, robotics and PCR testing and genomic sequencing for SARS-CoV-2, aiming to process up to 150,000 tests each day. There is every reason why such investment should be led by the NHS and Public Health as part of a national public health laboratory service, one that should be integrated with GP and other NHS services. The decision for these labs to be led in the main by private interests is further proof of ideologically driven policy.

7.6.4 A company linked to Lord Ashcroft, a major donor to and former chair of the Conservative Party, won a contract for £350m to provide laboratory staff for the Covid testing operation.[7.29]

The Leamington Lighthouse

7.6.5 Matt Western (Session 9) is Labour MP for Warwick and Leamington and Labour's Shadow Universities Minister. The Leamington Lighthouse Covid Mega Lab, first announced in November 2020, is sited in his constituency and was still not up and running when Western gave evidence in June 2021.

7.6.6 Western had been campaigning for months for greater transparency from Government and tried to hold Ministers to account over this project. He had no prior engagement with the DHSC or his local authority regarding the project, despite being the local MP. He was sent a letter by Health Minister Lord Bethell on 17 November 2020 with 'advance notice' of the announcement made on 16 November 2020. The other lab was going to be based in Scotland. Work on the Scottish

lab had stopped while the UK government assessed 'the long-term demand' for it.

7.6.7 The Government initially said the project could create up to 2,000 jobs. More recently, they've said around 1,800. They initially said it would be opened in early 2021. This later changed to Spring 2021. By June there was still no opening date that the Government will provide to him. His constituents who had been recruited to work at the lab still had no start date. Individuals had left other jobs, after being told the lab would open in early January 2021. Now without income, they contacted him for advice. He challenged the Health Secretary in the House of Commons to 'tell us what is going on, and can he confirm when the place will open'. He refused to provide an answer. Western wrote to Lord Bethell several times, but no one could give him a start date or explain the delay. There had been no response to his most recent letter in March.

7.6.8 Western referenced the report by Pat McGee entitled 'Mega-laboratory in Leamington Spa: a Trojan Horse for a Private System'. McGee is a former State Registered Biomedical Scientist, previously employed by Coventry and Warwickshire Pathology Services. The report says that the Government awarded the mega-lab contract to the private company Medacs without it being advertised or put out to tender – in much the same way as has happened with numerous PPE contracts. At least three other private companies have been involved in recruitment of staff – Blue Arrow, Lorien and SRG Talent. Western tried and failed to get more details of the involvement of private companies from the Government, whose public claim is that the laboratory is publicly owned and will be operated by DHSC as part of the NHS Test and Trace laboratory network:

> *'There is a clear lack of transparency, [there is] waste and cronyism surrounding the Government's contracting process throughout this pandemic, which equally applies to this project.'* (Western)

The key question is why the Government chose to set up a brand-new laboratory, rather than expand on existing NHS pathology services at University Hospitals Coventry and Warwickshire NHS Trust.

7.6.9 Earlier in 2021 there was an outbreak of Covid amongst the staff currently contracted to work at the site to get it up and running. At least 25 employees tested positive. It is an embarrassment that the Government cannot even protect staff working on the site of a lab set up for large scale Covid diagnostic testing. There are concerns regarding lack of regulation, accreditation and quality standards of the facility and its employees:

> *'[These] apply within NHS based laboratories. I have heard from scientists who fear the lack of regulation, poorly qualified staff and mismanagement at the facility could be reminiscent of the issues with the Milton Keynes laboratory.'* (Western)

7.6.10 Western was concerned about the lack of transparency and has been unable to find out details including how much this was all costing the taxpayer:

> *'The Government had admitted to him that some staff and suppliers are subjected to non-disclosure agreements, confidentiality clauses or specific terms of employment in place, which only adds to the secrecy surrounding this project ...There have been too many failures and too much taxpayers' money squandered by this Government for us to allow*

Ministers to avoid accountability in the way they are at the moment.'

7.6.11 Western summarised three main concerns regarding this project:

- A total lack of transparency
- Privatisation of NHS services, and
- Delay of the project

The concerns remain unanswered. The lab was declared open in July 2021 as the Rosalind Franklin Laboratory.[7.30]

7.6.12 Postscript: On 15 October 2021 a scandal broke over the failure of the unaccredited Immensa Health Clinic to identify and explain why at least 43,000 cases of coronavirus infection may have received negative PCR results from that private laboratory service during September and October. Just 0.2% of tests for one area whose tests were sent to Immensa in Wolverhampton were positive against an expected rate of 8%. The UK Health Security Agency temporarily suspended the lab's operations. Immensa was founded in May 2020 and given a Government contract worth £119m 3 months later for SARS-CoV-2 testing. It received a further contract worth £50m in July 2021. Its sister company in the UK, Dante Labs has been under investigation over its coronavirus-testing for travel tests.[7.31 7.32]

7.7 FAILURES OF PPE SUPPLIES WERE DETERMINED PRE-PANDEMIC

7.7.1 Testimony in Sessions 1 and 7 explained pre-pandemic Government policy of outsourcing NHS services and functions and how the Government continued this policy in responding to coronavirus. Time and again, the serious limitations of outsourcing had been exposed. Critical NHS supply functions had been outsourced in the years prior to the pandemic by NHS Supply Chain, who had subcontracted out PPE procurement and stockpiling.

7.7.2 With pandemic infection at the top of the country's risk register, pandemic planning exercises had been carried out. One such operation was Exercise Cygnus in 2016. In Session 1 (see report section 1.4), Gabriel Scally explained Exercise Cygnus:

'It was a training exercise aimed at influenza. The scenario was an episode of pandemic influenza. It involved ... 950 people and resulted in a report which had a significant number of important recommendations in it.'

7.7.3 As became clear in *The Sunday Times* team's book, *Failures of State*,[7.33] several key lessons and recommendations emerged. Urgent and drastic improvements were needed. Ring-fenced funding should be provided. There was a warning that 200,000 in the UK may die from pandemic influenza. Ventilator capacity was insufficient. Numbers of excess bodies would have to be managed. Quantity and specificity of PPE needed overhaul. Care homes would not cope with large numbers of elderly people discharged to them from hospitals to free up beds. There would be a serious economic impact. The warnings from pandemic training exercises were however mothballed and not made public.

7.7.4 Speculating as to why the Government ignored the recommendations, Scally said:

'I think it was because public health in general, the health of the people, became a lesser interest of the Government than it had previously been'.

7.7.5 This had serious consequences leading to the lack of ability to respond to the pandemic: contracts such as those given out by NHS Supply Chain had been exposed as failures. From the start, there was never an adequate supply of PPE. The Government argued that Cygnus was modelling influenza and the country was justifiably not prepared for the consequences of a novel coronavirus pandemic – PPE specifications and supplies, and the needs of hospitals and care homes. However, since the end of the Inquiry sessions, it has come to light that there was another pandemic dry run, also in 2016.

7.7.6 Exercise Alice has come to the Panel's attention more recently through the FOI requests of Dr Moosa Qureshi.[7.34] [7.35] Senior health officials modelling the impact of a coronavirus hitting the UK – just four years before the Covid pandemic – concluded that there was a serious need for stockpiles of PPE, a computerised contact tracing system and screening for foreign travellers – predictions of the key areas of failure in the first year of the pandemic from February 2020.

7.8 FAILED SUPPLIES OF PPE COST LIVES

7.8.1 At the start of the pandemic, in February 2020 there were clinicians watching what was happening in China and in horror that nothing seemed to be happening in response in the UK. Lancet articles from Wuhan health professionals, WHO's escalating advice and warnings and the situation in northern Italy were picked up on social and mainstream media.[7.36] [7.37] One thing was clear to staff: their lives were on the line and PPE was going to be the difference between life and death. National supply and distribution of PPE and essential equipment in the right place at the right time were going to be key.

7.8.2 Nevertheless, the Army was having to bail out a failed distribution chain. Stockpiles of PPE delivered were found to be inadequate or out of date, leading to a desperate rush to find suppliers; distribution problems related to previous privatisation of NHS Logistics also caused difficulties in keeping up with demand. Established procurement routes used by the NHS were ignored. Government messaging was complacent:

> *'The country has a perfectly adequate supply of personal protective equipment) at the moment ... [supply pressures are] completely resolved.'* (Dr Jenny Harries, Deputy Chief Medical Officer, 20 March 2020 at daily Downing St. press briefing[7.38])

7.8.3 There is a very stark contrast between the assessment of the provision of vital PPE equipment by the Government and their advisers on the one hand and frontline staff on the other. With Government guidance on PPE changing 40 times (Agius) there was a strong suspicion that policy on PPE was adjusted to meet failing levels of supplies rather than health and safety principles on managing risk of airborne transmission of a fatal virus (see report section 5.4).

7.8.4 The inquiry heard a very different reality from Michelle Dawson, consultant anaesthetist (Session 7). Dawson told the Inquiry of how, at the start of the pandemic, she had watched hospitals being built in Wuhan in a matter of days:

> *'This is going to spread around the world. This is going to impact every country.'*

7.8.5 As the virus spread and patients were flowing into hospitals, the availability of PPE was in serious trouble:

> *'This was in the middle of March, when we had nothing ... At that time, we were working on Covid ICU with no PPE whatsoever, unless we went within six feet of a patient, because we had to conserve the stocks.'* (Dawson)

Dawson felt dazed that nothing seemed to be happening (in the UK). A large group of medics around the world, were sharing information on Twitter about Covid as it crossed continents. But in the UK she had seen 'absolute inaction'. The PPE supply situation was serious. A colleague in another hospital had told Dawson at the end of February/beginning of March that they had run out of PPE, apart from for ITU.

Opportunities rejected

7.8.6 Staff were going into ITU without PPE believing it was safe because patients were intubated and that coronavirus was within the tubing, spread by droplets. But in fact it was spread much more dangerously by aerosol. As the Inquiry heard from palliative care consultant Rachel Clarke (see report section 4.19), Dawson realised it was not only the NHS not being supplied with the PPE, but also hospices and care homes, which pre-pandemic had been getting PPE via the NHS Supply Chain. Because these organisations were not classed as hospitals, they were expected to go into a global fight for PPE on their own.

7.8.7 Dawson realised that the pandemic stock of PPE was greatly rundown. She knew it was not just the UK: 'the whole world needs the same stuff at the same time'; that there were a limited number of manufacturers and virtually none in the UK. Dawson worked in procurement in the NHS in addition to her anaesthetist role, she knew about the processes and legalities.

7.8.8 She had started looking to see if she could open up supply chains through her contacts. She had managed to open up a supply chain directly via the Chinese Government for 50 million high quality close-fitting FFP3 masks, the type necessary for working with Covid patients. Dawson and colleagues had contacted the Cabinet Office about the China supply by phone and email and followed it up a week later, but nothing had happened. So those masks had been sold to Germany. A further offer of 30 million masks a month was not acted on either. The PPE on offer had fulfilled all the quality criteria, had the correct product codes, but they were not followed up by the Government.

7.8.9 The fight to get PPE was very aggressive because everybody needed it:

> *'America was buying futures on PPE ... They weren't buying what was in the warehouses. They were buying what would be made [in the future]. And then there are the people who were willing to sell stuff that was fake. There were people willing to just profiteer really, and the prices rose and rose.'* (Dawson)

7.8.10 However, the Government was not listening. Highly experienced and knowledgeable NHS staff who knew what they were talking about (including the BMA itself, see below) were ignored. Dawson said there was no consultation to her knowledge with anaesthetists and intensive care clinicians or Royal Colleges on Government procurement decisions. Instead, the Government continued to rely on outsourced contracts with unproven companies, including start-ups with no track record whatever in PPE or working

with the NHS. They handed out hundreds of contracts for supply of PPE worth tens or hundreds of £millions, awarded to companies with no previous experience, including a pest control business and a confectioners.[7.39] Undoubtedly there was profiteering. The procurement process, via a secretive, ineffective and uncoordinated private route, has been criticised by the National Audit Office for questionable practice.

Forced into self-help

7.8.11 In March 2020, a group including doctors, businesspeople and others had got together to set up a charity (Heroes[7.40]) and started raising money and sourcing masks from industry. Huge amounts of PPE were donated by companies; one businessman had couriered it out with his fleet of vans to wherever it was needed. A website was set up which allowed anybody anywhere in the UK to put out a plea for help if they were running out of PPE. Later on, there were similar situations with gowns, visors and other items of PPE. The charity not only organised PPE but also food drops and gifts to cheer up staff.

7.8.12 To add insult to injury, Dawson had been told that hospitals who had sourced PPE for themselves (out of necessity) outside official channels had recently been informed that they were not going to be refunded by Government, because they shouldn't have done it, possibly costing them tens of millions of pounds.

The British Medical Association was also ignored

7.8.13 David Wrigley testified that the BMA was also hugely concerned about the lack of PPE. The Inquiry had already heard that the Government had pre-pandemic delegated large parts of the management of the procurement process to supply chains, a complex web of external companies. Procurement was based on the Government's just-in-time business model wholly unsuited to the pandemic emergency. This left the Government less able to respond in an agile way.

7.8.14 The BMA had been contacted daily by doctors about lack of supplies, with hospitals sometimes one day or less from running out and no idea where supplies were coming from. There was also concern about the poor quality of the PPE available.

7.8.15 There was no shortage of offers of reliable help: over 70 companies contacted the BMA about being able to supply good quality PPE. They had contacted the Government but hadn't received any response. This was as hospitals were on the verge of running out of PPE. Just as happened to Dr Dawson and colleagues, the offers passed to the Department of Health by the BMA received no response. NHS in-house expertise was completely bypassed.

7.8.16 The BMA had concerns over reports about procurement going outside the normal rules governing the NHS. This was not new. Previous BMA reports had highlighted contracts for goods and services being awarded to private firms with no relevant experience or expertise. Now the Government opened up high priority lanes that led to fast-track offers of PPE contracts, based not on what you knew but who you knew to get these 'golden nugget' contracts.

7.8.17 It raised serious governance concerns. There had not been proper oversight of the procurement of those deals and no transparency. Governance needs to be much more robust. Companies often hide behind commercial

confidentiality as an excuse. Public notices with contract details are required to be published within 30 days and The Good Law Project has taken the Government to court to successfully challenge them on these issues. In February 2021 a High Court judge ruled that Matt Hancock had acted unlawfully in failing to publish contracts.

Comparing outcomes from outsourced contracts with the NHS-led vaccine campaign

7.8.18 Wrigley said that the concerns about private contracting in the NHS were not new. Many of the companies given NHS contracts have poor track records. For example, in 2012 Serco had admitted to presenting false data over 250 times about the performance of its out-of-hours service in Cornwall: 'At one point they had had one GP covering the whole of Cornwall, but they had tried to cover this up.'[7.41] In 2018 Serco had been reported to have provided inadequate staff training at a breast cancer hotline, where patients were being assessed by call handlers with one hour's training.

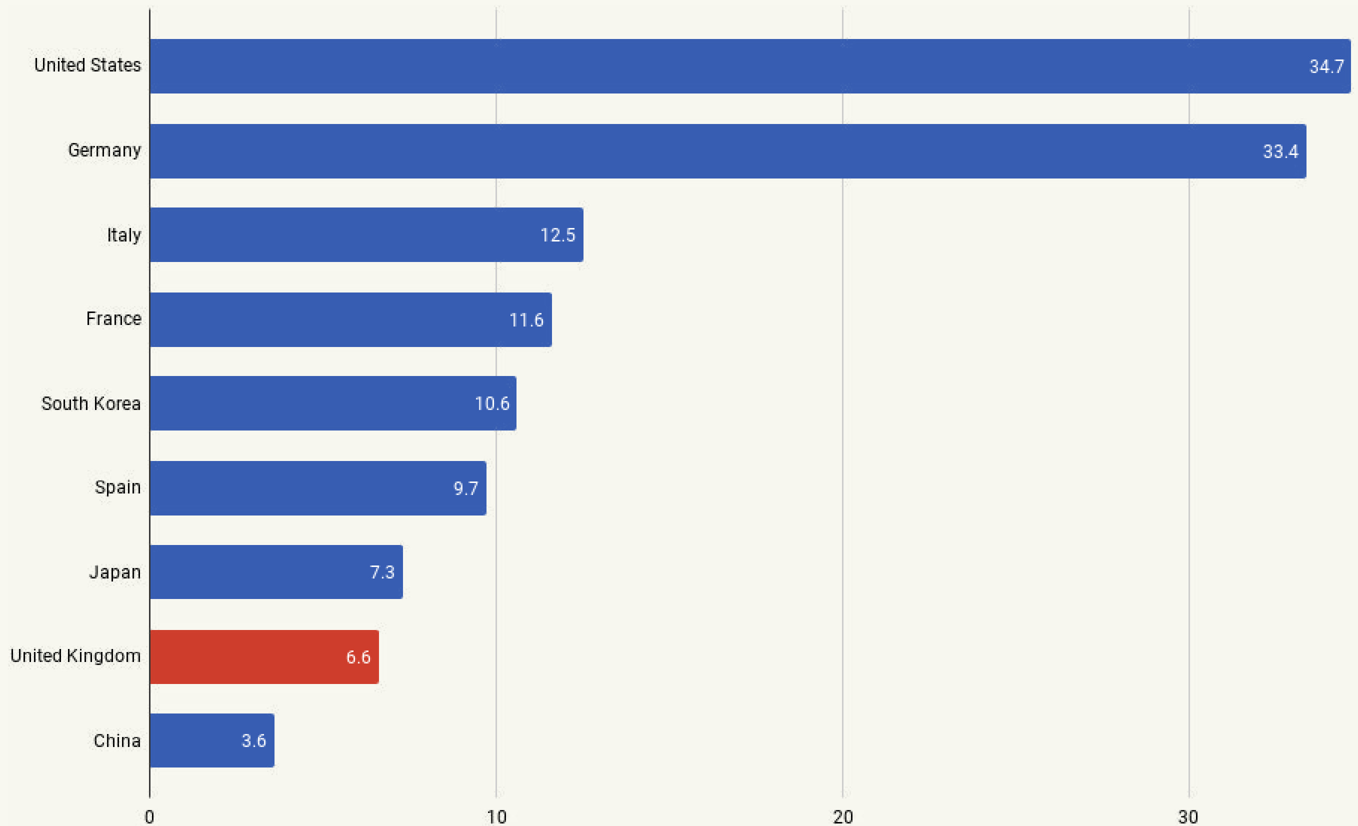
7.8.19 In the pandemic, it was about life and death. Companies such as these were put in charge of providing vital services and equipment to protect the workers on the front line. Not having confidence in these companies made those working with patients 'really frightened about the equipment they were using'. The BMA is committed to a publicly funded and publicly provided NHS, with significant and sustained funding to strengthen the NHS and local Public Health capacity and expertise.

7.9 VENTILATORS

7.9.1 The pre-pandemic baseline of intensive care beds and ventilators saw the UK very low down the table in international comparison, half the number of Italy and one fifth of Germany. The failure to action the recommendations from past pandemic exercises had consequences including the very real threat of the UK running out of ventilators.

7.9.2 Dawson said that the EU had contacted the Government saying that they were going to do an EU contract for ITU ventilators and had invited the UK to join. The Government said no. When news of this broke in the press, they said that they had not received the email, which turned out to be untrue. The Government then made headline-grabbing announcements of how their deals with private sector contacts would save the NHS. Much publicity was given to communications between James Dyson and Boris Johnson – but, as the Inquiry heard, no Dyson ventilators were ever produced. And in an attempt to build up NHS capacity at the start of the pandemic, the Government bought 30,000 ventilators for £569 million; less than 10% were used.[7.42 7.43 7.44]

7.9.3 Michelle Dawson had been incredulous at this situation, including at the contract that was offered by the Government to Dyson. She told the Inquiry that ventilators, like other sophisticated equipment, range from the very simple to the exceedingly complex. It was the exceedingly complex ones that ITUs needed. ITU ventilators have different computer programmes and are a 'massively complex piece of kit' which have taken years to develop. There were numerous different parts – consumables



Source: WHO, American journal of respiratory and critical care medicine, Society of Critical Care. Were countries prepared for scale of outbreak? [reproduced by BBC 3 April 2020]

such as tubing and filters – which had to be compatible with the ventilator:

> *'To have all of the software written, the hardware correct, the compatibilities made, the consumables manufactured – it was going to take years. But we already had them. They'd already been designed. They'd already been through all of the quality assurance. There were multiple companies in the UK who already made fit-for-purpose ITU ventilators, and they approached the Government saying "we can make these, we just need funding, and then we can make these for you". And they were ignored.'* (Dawson)

7.9.4 Dawson compared giving Dyson a contract to make ventilators from scratch to asking somebody who makes vacuum cleaners to make a fighter jet or helicopter in a month. In the end Dyson did not supply the NHS with any ventilators.

7.9.5 Most telling of all, the limiting factor in any case wasn't ventilators – it was staff. Dawson felt that the failure to support the NHS and its staff facing the pandemic contributed to the damaged morale and exhaustion of staff witnessing those decisions and suffering from their impact:

> *'Every single day at work, there's an NHS worker in tears in the changing room. Terrible because we saw colleagues dying ... and we were terrified we would be the next one ... and you just have to keep going in there and keep working.'* (Dawson)

7.10 PRIVATISATION OF DATA AND GOVERNANCE OF CONTRACTS

7.10.1 Rosa Curling, lawyer and co-founder of Foxglove Legal campaign organisation, gave evidence on data and pandemic contracts. The rewards for proper data use in the public interest are potentially lifesaving. Health data is incredibly useful and there is a wealth of extremely important and helpful information that could certainly make our NHS services stronger and safer – never more important than in a pandemic if used with integrity. The potential use for high level data in tracking the pandemic and responding quickly is self-evident.

Trust

7.10.1 The question to pose is whether we can make sure that data remains a public asset for the public good with safe data-sharing compliant safeguards, rather than allowing unprecedented access to huge multinationals like Amazon, Google or Alphabet (Apple), with enormous corporate resources and power, and incentive to monetise and market patient data:

> *'The risks involved, going from minor embarrassment to a total corruption of trust in the medical profession, are really serious.'* (Curling)

7.10.2 The issue of trust has recurred at every step of the pandemic and is central to data issues: centralised data is key to enhanced emergency planning. Yet, as with so many other Government decisions, the combination of unprecedented centralisation of data, total lack of transparency of contracts and handing unmonitored control of use of data to major private companies indicates that the lack of trust from the public has been well-founded.

NHS data: public safety and private exploitation

7.10.3 Curling told the Inquiry that Foxglove Legal was challenging the collation of NHS data called the Covid Data Store. It was set up in March 2020, announced very quietly on an NHS blog and involved a series of different contracts and agreements with US tech giants Amazon, Microsoft, Google, plus Faculty and Palantir.

7.10.4 The Data Store would be a 'single source of truth about the pandemic' that was 'unprecedented' according to the Department. It was for the first time collecting health and social care data from a variety of different sources, collated on a national level, and held in one single place. It was collecting health data in a way not seen before.

7.10.5 NHS data is unique – 'the largest set of machine-readable health data on the planet' – with an estimated value of about £10 billion a year if marketised by the tech corporations across the world who exist to 'aggregate and monetise data'. During the pandemic, normal rules about procurement and data protection were being set aside. Foxglove wanted to ensure that those emergency arrangements didn't become the norm without the consent of the public.

7.10.6 The Government revealed virtually no details about the data deals with the private companies nor about the types of data that were going to be stored in the Data Store. It was suggested in the press at the time that these tech companies were hoping to bed down in the NHS long-term. This raised several questions: on public trust in that the companies would

have access to 'all of our most sensitive, confidential medical information'; on what security was in place to protect it; on who would have access to it and on what terms; and whether the Covid Data Store would come to an end when the pandemic resolved.

Transfer of GP patient data to NHS Digital

7.10.7 Operating under the greater freedom afforded by the emergency coronavirus legislation, the Government and NHSE were making further bolder plans for data centralisation for the longer term. Rosa Curling told the Inquiry that the Secretary of State had issued a Direction for England that GP-held patient data should be transferred to NHS Digital on 1 July 2021. In addition, in keeping with the new White Paper (February 2021), some social care data would also be transferred resulting in 'a huge mass data set of health and social care data' to be held by NHS Digital. The data – a collation of over 50 million GP patient history and medical records – was to be transferred from GP records on 1 July straight up to NHS Digital, unless patients opted out.

7.10.8 The legal obligation is on the Secretary of State and NHS Digital to notify the public about such a proposal and to seek patients' individual consent. Curling reported that, when a similar attempt was made in 2014, every single patient was written to, and their consent was requested. This time, it did not happen. There was a website statement and a few tweets which basically asserted that, unless an individual were to opt out, there would be an assumption that they had consented. Foxglove was concerned about whether that was lawful under data protection law and were preparing a challenge.

7.10.9 Days after Curling's evidence to the Inquiry and faced with growing public opposition and one million patients choosing to opt out, the Government suddenly announced on 8 June 2021 that this date had been moved to 1 September. Subsequently the deadline was deferred again with no end date. Though the timetable in this ministerial direction has been postponed, fundamental issues raised must be addressed. To restore public trust and to respect data governance, there needs to be a full and proper consultation process in which people are given full information about any changes.

7.10.10 There were further serious questions. What was NHS Digital going to do with that information? What limits do they have in relation to use of those data? Who can access the data? For what purposes can it be used? Is there a meaningful consent framework that permits patients to differentiate between academic and for-profit access?

7.10.11 The inquiry was reminded that health data is incredibly useful and there is a wealth of extremely important and helpful information that could certainly make NHS services stronger. However, public trust must be maintained, and data safeguards ensured.

7.10.12 The potential commercial value is indicated by Palantir agreeing to be paid just £1 for the first contract, establishing them in position. They then got £23 million for the next stage. Curling questioned the suitability of a company like Palantir, very well known in the US for its role in controversial intelligence and security work, and as a major Donald Trump donor. It has been criticised repeatedly by its own

staff over its role in the US Immigration and Customs Enforcement (ICE agency) in relation to family separations at the US-Mexico border. The question must be asked: is this the sort of partner in the long term, that the NHS wants to be signing deals with? Would their very involvement not undermine confidence in the health service amongst the very communities where the Government states it's trying to now shore up trust, for example, in relation to the vaccination programme?

7.11 GOVERNANCE

7.11.1 The Nolan Principles of Public Life are accepted as a standard for behaviour in public life. The seven principles – Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership – have no statutory basis but are published and promoted by the Commons Committee for Standards in Public Life.[7.45]

Conflict of interest and cronyism

7.11.2 Several Inquiry sessions heard testimony questioning the governance of contract awarding during the pandemic. Government contracts to the private sector have been eye-watering. £18bn in coronavirus-related contracts during the first six months of the pandemic, most with no competitive tendering processes.[7.46] £22bn for the first year of NHS Test and Trace expanded to £37bn by the second year – a total larger than funding for the police and fire services combined. Multimillion pound contracts handed to big private outsourcing firms. The failed NHS contact tracing app cost the taxpayer £11.8m. Randox Healthcare were paid £133m for test kits that were later withdrawn as faulty. There have been many highly public failures (see 7.6.12 above) and soaring profit margins for contracts. In many instances there are political connections to the Conservative Party.[7.47]

7.11.3 A major risk inherent in the awarding of contracts for public services to private interests is the conflict of interest between maximising company profits and the delivery of quality services. The Nolan principles were breached when contracts totalling £1.5bn went to companies with connections to the Conservative Party without openness.[7.48] In one of two highly critical reports, the National Audit Office concluded in November 2020:

> *'The high-priority lane [with Government and political contacts] sat alongside a normal lane established to assess and process other offers of PPE support ... About one in ten suppliers processed through the high-priority lane obtained contracts ... less than one in a hundred suppliers ... came through the ordinary lane.'*[7.49]

Failures of governance in pursuing contracts

7.11.4 The Government's justification was the urgency of the situation and the legal cover of the emergency coronavirus legislation. However, the duty of public office was to make rational and informed decisions. There was an irrational failure of Government to respond to clinicians, the BMA and current PPE suppliers willing to supply PPE. Instead, decisions were pursued which wasted vast sums of public funds with serious consequences. The process for awarding many failed private contracts has been grossly negligent.

Failure of candour

7.11.5 At a time of national emergency, when public trust was at a premium, that trust was undermined by large numbers of high-value contracts being awarded without transparency for the public. Not only were contract details withheld, but the implications for public interest issues were kept from public view – such as whether contracts protected the public from the risk of data abuse or were transparent in their content, extent and duration.

7.11.6 Wrigley told the inquiry that the Good Law Project's legal efforts had forced disclosure of various contracts. A legal challenge to Matt Hancock on the secret contract given to Palantir has been successful but the DHSC has been slow to comply. Only now, post-Inquiry, the Information Commissioner has found the DHSC to be in breach of its obligations under the FOI Act and instructed the DHSC to reveal the details of 47 contracts awarded to companies in the VIP lane to the Good Law Project within 35 days from 18 October 2021.[7.50]

Legal challenges on governance

7.11.7 The Government has been held to account for its governance shortcomings in the media and by parliamentary bodies, but it has taken legal challenges to pressure the Government into revealing contract details or force their hand when found to have acted unlawfully.

7.11.8 There have been important successes some of which are referred to in this report:

- Then-Secretary of State for Health and Social Care, Matt Hancock was found in breach of the law on failing to disclose contract awards within the statutory time frame through the Good Law Project's judicial review
- The DHSC must now place details of 47 VIP-lane contract awards in the public domain, following the Good Law Project's successful complaint to the information Commissioner
- The public disclosure of the Palantir contract through legal action of openDemocracy and Foxglove
- FOI requests by Foxglove Legal for copies of the contracts on the NHS Data Store and related Data Protection Impact Assessments (DPIAs) documents – only revealed after threatened legal action
- Public opt-outs and threat of legal action by Foxglove on the transfer of GP data
- Freedom of Information requests and associated legal actions led to the revealing of Exercise Cygnus and Exercise Alice, through the work of Dr Moosa Qureshi and Leigh Day Solicitors

7.12 CASE STUDY OF THE NHS DATA STORE AND PALANTIR CONTRACTS

7.12.1 Rosa Curling told the Inquiry that the Data Store could of course, partly be in the public and NHS interest, so they had made a series of FOI requests, asking for copies of the contracts and also DPIAs, documents which are like equality impact assessments. These are basically required of public bodies, to think about what impact, from the data rights point of view, the Data Store would have for individuals.

7.12.2 The deadline for the FOI requests had not been met, so Foxglove had given notice of the start of legal proceedings, with a deadline of May 2020. As a result,

the Government eventually published the contracts (with some information redacted) on 5 June 2020, the day before proceedings were due to begin. The DPIAs were published a few days later, but had been completed after the event, which is not what the law requires.

7.12.3 Foxglove took a second case about DPIA in relation to the awarding of two further Covid-related contracts with these companies; and a third contract, signed with Palantir for two years, going beyond the expected end of the Covid pandemic. The brief was wider and required public scrutiny.

7.12.4 Curling explained that the DPIAs are not just mere legal formalities but key to good governance. The public has the right to be consulted about how their medical data is used and with whom it is shared. While there are potentially life-saving rewards for proper data use in the public interest, 'the risks involved, going from minor embarrassment to a total corruption of trust in the medical profession, are really serious'.

7.12.5 DPIAs are about ensuring accountability in a period where trust in some of our health institutions has been eroded. The public needs to be asked for their consent about whether they want their most sensitive, confidential information to be shared with private corporations or whether in fact, they want that data to be kept within public bodies, as a public asset for the public good. If this arrangement is going to be changed, then a democratic mandate is needed:

> *'You have to get proper consent for that to happen. Otherwise, you really are threatening, I think, the trust and patient confidentiality that is really at the bedrock of our National Health Service.'* (Curling)

7.12.6 There are many examples of flagrant conflicts of interest, lack of candour and openness. The NAO reported their findings on test and trace[7.51] and concerns about the Government procurement process (see para 7.9.2). The public has every reason to question whether the current system for regulating conflicts of interest is fit for purpose. There have been calls for giving the Nolan principles and regulations on conflict of interest a statutory basis independent of Government.[7.52]

THE PEOPLE'S COVID INQUIRY

The People's Covid Inquiry took place from 24 February to 16 June 2021.

A panel of four, chaired by Michael Mansfield QC, heard evidence from over 40 witnesses including bereaved families, frontline NHS and key workers, national and international experts, trade union and council leaders, and representatives from disabled people's and pensioners' organisations.

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