The PPE procurement scandal—who pays and who profits?

Niamh Thompson, Martin McKee, Dina Balabanova

“Had to stop CPR today for a full five minutes on a patient who arrested when someone realised he had covid symptoms. No PPE on the resus trolley. The full resuscitation team were exposed to aerosolised covid. Finally found some FFP3 masks locked in a cupboard because the matrons had been told they were ‘too valuable’ to leave lying around. He died.”

These are the words of a medical registrar in an NHS hospital in March 2020. They remind us how fine the margins for error are in running a health service. A health professional whose actions kill a patient can expect to be investigated and potentially disbarred by their professional regulator. But what about the politicians who implemented the creation of a deeply flawed system for procurement during a pandemic that failed to consistently supply stocks of usable personal protective equipment (PPE)?

We only know how the NHS procurement system failed thanks to lawyers working for the Good Law Project, who forced the government to disclose the existence of a “VIP lane” for suppliers. Created in March 2020 to fast track covid-19 related supplies for a dangerously understocked NHS, this enabled people with the right connections to gain access to those buying equipment. Conservative politicians helped to “open doors” or referred suppliers with nepotistic connections to ministers. Critically, the normal checks and balances were abandoned and contracts were awarded, in some cases, to new companies without any experience of supplying what was needed. This happened while well established companies with experience in providing PPE struggled to be heard.

What happened next is best explained in numbers.

- **Ten**: the factor by which a company was more likely to have a contract accepted if it was in the VIP lane
- **1 in 5**: the proportion of emergency covid-19 contracts handed out by the government that had “red flags” for corruption
- **£2.2bn**: the known value of contracts given to Conservative party affiliates
- **£3.6bn**: the total value of contracts whose award merits further investigation
- **£12bn**: the amount that National Insurance was raised by to pay for the additional costs faced by the NHS and social care because of the covid-19 pandemic (currently in limbo pending a second budget).

In short, the VIP lane may have facilitated irregularities, and in some cases corruption, on a monumental scale, with the bill paid by the taxpayer.

How was this allowed to happen? The importance of speed in the first days of the pandemic was unquestionable. All clinicians know that when speed is of the essence, mistakes can happen. The question is not “did speed cause mistakes?” but rather “was speed a justification for facilitating corruption?”

Revelations in emails obtained in ongoing litigation reveal that civil servants knew that what was happening was, at the very least, extremely questionable. Corruption involves failure to act, collusion, and obfuscation among many actors and is often facilitated by social networks that reflect political and personal interests. It flourishes in the absence of transparency and the presence of opportunity.

When the government spent £87m on an antibody test whose accuracy Public Health England had expressed concern about, civil servants delayed publication of their evaluation, noting that “Number 10 is now aligned” with holding the information back. Civil servants were over-ruled when attempting to raise safety concerns about ineffective PPE. Companies that provided equipment found unfit for use—such as Ayanda Capital, who won a £250m contract for 50 million unusable masks—are now registered offshore where they can avoid scrutiny. Meanwhile Liz Truss (now our prime minister), whose adviser facilitated that deal, was later promoted to foreign secretary.

The UK is not unique in facing this problem; globally, 10%-25% of healthcare funding is estimated to be lost to corruption each year. The Department for Health and Social Care itself is potentially implicated, and the NHS CFA is accountable to ministers. This casts doubt, therefore, on the credibility of either organisation in tackling the matter. The forthcoming public inquiry must look at this, but it is not even possible under the rule of law.

So who will hold the rule breakers to account? The NHS Counter Fraud Authority (NHS CFA) seems to be the obvious institution. However, investigating irregularities on a governmental scale are out of its league. In the financial year 2020-21, NHS CFA reported having reduced fraud affecting the NHS by £54m. The sums involved in the pandemic response are billions greater. The Department for Health and Social Care itself is potentially implicated, and the NHS CFA is accountable to ministers. This casts doubt, therefore, on the credibility of either organisation in tackling the matter. The forthcoming public inquiry must look at this, but it is not even possible under the rule of law.

Tackling corruption is an unending task for any nation. Enforcement will only work with political commitment and a coordinated, “whole-of-government” approach. At its core, it is a political question: do those in power feel entitled and able to use government for their own benefit at the expense of its core purpose? Penalties for perpetrators
are only effective when they make those in power fear the consequences of engaging in corruption more than they covet potential gains. This requires oversight—from citizens, government bodies, parliament, and internal party structures. The Public Accounts Committee and the National Audit Office have both produced meticulous evidence which would support an investigation, but it is yet to be acted on.17 18

Ignoring corruption comes at a cost, particularly during pandemics and economic crises when the NHS budget is already stretched. Ultimately, that cost is paid by citizens who suffer hard to access and reduced quality care. Without better oversight, accountability, and the political will to act, we can be sure that unacceptable scenes like the one described on that busy hospital floor will be repeated in the next pandemic.

Competing interests: NT worked in critical care during the second wave of the pandemic as a clinical fellow. WMK is a member of Independent SAGE.

Provenance and peer review: not commissioned, not peer reviewed.

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