

Procurement and Supply Chain Management during the COVID-19 pandemic

07 May 2021

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Summary

Introduction

1. The rapidly evolving nature of the COVID-19 pandemic has called for an extraordinary response from the Government of Jersey as it has sought to save lives and protect health and livelihoods on the Island. The principles of good governance, transparency, value for money, effective internal control and accountability for the use of public funds remain during a time of emergency. Whilst public financial management systems need to be responsive and flexible, it is essential that they continue to ensure value for money and minimise the risk of fraud and corruption.
2. In responding to COVID-19, the Government of Jersey had to procure goods, services and works with extreme urgency and in large volumes. This report evaluates procurement processes and supply chain management in respect of the supply of certain essential equipment and resources during 2020. In particular, the report considers the procurement of:
 - ventilators
 - Personal Protective Equipment (PPE)
 - testing kits; and
 - the Nightingale Hospital.
3. The review I report here is one in a series I am undertaking to evaluate the Government's response to the COVID-19 pandemic.

Key findings

4. The key findings from my review are as follows:
 - the Government's decisions on procurement of supplies were based on independent, expert scientific advice on the potential impact of the COVID-19 pandemic, prepared in March 2020. The 'reasonable worst case scenario' used as a basis for procurement and supply decisions has not materialised to date
 - the Government has benefitted from its close relationship with the UK Department of Health and Social Care (DHSC). The DHSC has provided a total of 45 ventilators, initially on loan, at no cost to the Island. These were subsequently donated. The DHSC has provided in excess of £5 million of PPE

and secured between £1.2 million and £1.5 million of laboratory testing capacity, all free of charge to the Island

- detailed business cases were prepared for the procurement of PPE, testing kits, and the Nightingale Hospital. These included consistent consideration of commercial risks
- due to urgency, much of the procurement of goods and services was not subject to tender and required exemption from the requirements of competitive tendering set out in the Public Finances Manual (PFM). A small volume of procurement was in breach of the PFM
- as well as that provided by the UK Government, the Government of Jersey procured large volumes of PPE at a cost in excess of £5 million from a range of suppliers from the early stages of the pandemic. The Government has been successful in meeting Island-wide requirements for PPE. Some concerns over sub-standard PPE supplies continue to be investigated by officers in liaison with appropriate authorities
- a detailed testing strategy for both diagnosis and surveillance was developed quickly with capacity for analysis on-Island and in the UK. As part of the initial procurement of testing kits, the Government bought uncertified rapid serology tests at a cost £1.3 million. These tests were purchased prior to the UK Medicines and Healthcare products Regulatory Agency (MHRA) releasing its specification criteria. The tests subsequently failed to fully satisfy the MHRA criteria which limits the use of the tests in practice; and
- a Nightingale Hospital for 180 patients was designed, commissioned, built and equipped at a total cost of £10.11 million in under six weeks. The Nightingale Hospital has not been used. A detailed and costed decommissioning plan was not prepared at the start of the project in respect of re-instatement of the site and disposal of fixtures, fittings and equipment.

Conclusions

5. Early and rapid action ensured that the procurement response provided capacity and flexibility to deal with the COVID-19 pandemic risk. The Government was alert to commercial and fraud risks in its procurement of essential supplies for the pandemic.
6. The consistent use of a 'reasonable worst case scenario' model from March 2020 to inform procurement decisions has resulted in the procurement of some

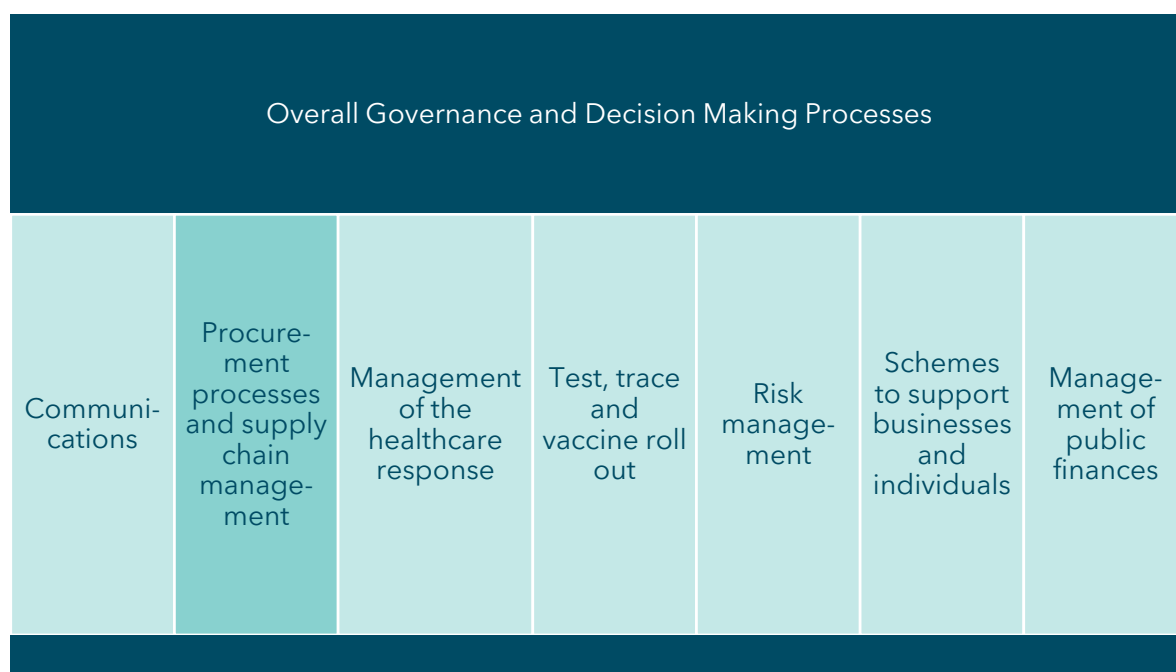
facilities, equipment and supplies that may never be used. A detailed plan for the future use of supplies and equipment should be developed to minimise potential waste.

7. The Island has benefitted from the UK Government provision of equipment, supplies and testing capacity free of charge during the pandemic. This is set to change during 2021 and the Government should re-evaluate its future procurement strategy to ensure value for money continues to be achieved.

Objectives and scope of the review

8. The review has evaluated the effectiveness of procurement processes and supply chain management in respect of:
 - ventilators
 - PPE
 - testing kits; and
 - the Nightingale Hospital.
9. The review is part of a series of reviews I am undertaking looking at the Government's response to the COVID-19 pandemic as shown in Exhibit 1.

Exhibit 1: Comptroller & Auditor General reviews of the Government response to the COVID-19 pandemic



10. The review approach is explained in detail in Appendix One.
11. The review has focussed on how public money has been used by the Government to address the supply requirements outlined above. The review does not extend to:

- considering how ventilators are used by Health and Community Services (HCS), the role of ventilators in treating COVID-19, or the safety, effectiveness, functionality or any other aspect of ventilators' performance
- the supply and distribution of PPE to organisations and individuals across the Island
- the testing strategy adopted by the Government
- the business cases and costs of later testing programmes such as the Test to Travel initiative; or
- any utilisation of the Nightingale Hospital.

Detailed findings

Introduction

12. For each of the four procurement areas I have reviewed, I have evaluated how specific needs were assessed and how the subsequent procurement was undertaken. In each of the procurements areas I considered, the assessment of needs was supported by a model developed by Public Health England (PHE) and the UK Scientific Advisory Group for Emergencies (SAGE). This model was produced on 16 March 2020 and showed a 'reasonable worst case scenario' for UK Crown Dependencies and Overseas Territories, taking account of factors including small populations and island environments.
13. The model forecast the percentage of the population that would show symptoms of COVID-19 and how many people with symptoms would require hospital care, including intensive care, over a defined period. The 'reasonable worst case scenario' has not materialised to date, however the model has remained a reference point for needs assessment and procurement activity.

Ventilators

14. Ventilators are medical devices that assist or replace a patient's breathing. The treatment of patients with COVID-19 can require the use of ventilators. There are two main types of ventilators used - non-invasive and invasive.

Needs assessment

15. On 13 March 2020, following an assessment of need, HCS instructed the Commercial Services team to procure 12 invasive ventilators. This request was considered as 'business as usual' activity to be funded from existing budgets. Therefore, despite the growth in volume and exceptional nature of the proposed supply, it was not the subject of a specific business case as new funding was not being requested.
16. A subsequent presentation by the Director General for HCS dated 4 April 2020 confirmed the existing invasive ventilator capacity of 24 machines and recommended sourcing an additional 20 invasive ventilators to bring the capacity to 44 in total.

Procurement

17. Attempts to procure 12 invasive ventilators were in hand from mid-March 2020. An early order was placed for two new ventilators on 13 March 2020 and these were delivered from the usual supplier in early April 2020. A further order was placed with a different supplier on 17 March 2020 for 10 invasive ventilators at a cost in excess of £200,000. This order was with a different supplier due to embargo restrictions on the earlier supplier, applied by the UK DHSC. Four companies were approached with only one able to take an order at the time. Ultimately, this order was also subject to embargo and was not delivered. HCS also purchased five non-invasive ventilators during March 2020.
18. From March 2020, ventilators were very difficult to source worldwide and, where they were available, this was only at a high cost with supply focussed on large governments rather than smaller jurisdictions. In recognition of this, on 20 March 2020, the UK Cabinet Office indicated its support under a Ventilator Loan Programme. Five invasive ventilators were received by Jersey under this loan programme on 26 April 2020.
19. As well as the five invasive ventilators, 20 non-invasive ventilators and 20 Continuous Positive Airway Pressure (CPAP) units were loaned as part of the programme. A further 20 CPAP units were provided by a benefactor.
20. On the basis of the information provided to me, the actions taken provided a total capacity of 31 invasive and 70 non-invasive ventilators by 30 April 2020 as shown in Exhibit 2. These volumes however are not consistent with those reported by the Minister for Health and Social Services on 30 June 2020 of 36 invasive, 39 non-invasive and 40 CPAP units. These volumes are also not consistent with the figures of 26 invasive ventilators and 39 non-invasive ventilators confirmed by the Director General for HCS in February 2021.

Exhibit 2: HCS Ventilator Capacity

Type	Existing	New	Loan	Total	Target
Invasive ventilators					
Invasive	5	2	5	12	
Invasive transfer	2			2	
Invasive Magnetic Resonance Imaging (MRI)	1			1	
Anaesthetic machines*	13			13	
Ambulance pneumatic	3			3	
	24	2	5	31	44
Non-invasive					
Non-invasive ventilators - low flow	5	5		10	
ResMed ventilators - DHSC Loan			20	20	
Continuous Positive Airway Pressure (CPAP) DHSC Loan and Benefactor		20	20	40	
	5	25	40	70	
Total	29	27	45	101	

* Can be converted for use as ventilators
Source: HCS records

21. A number of contributing factors might have led to an inconsistency in the reported number of ventilators. These include the status of machines that could be converted for use as ventilators as well as the assumptions made regarding the ventilators on loan and the ventilators ordered.

22. Whilst less than the requirement identified during March 2020, the ventilator capacity has proved to be more than sufficient. To date, the use of ventilators has not been significantly different from the typical use in the hospital. The flexibility provided by anaesthetic ventilators identified as a contingency has not been required. Up to the end of December 2020, a total of 12 COVID-19 patients had required invasive ventilation for a combined total of 83 days.
23. Expenditure by the Government on ventilators has been £37,000 on invasive ventilators and £10,875 on non-invasive ventilators since March 2020.
24. At the time of my review, the loan ventilators from the UK remained in HCS with an agreement to return these to the UK when no longer required. This arrangement has since been superseded by an agreement under which the DHSC has donated the equipment to the Government of Jersey.

Recommendation

- R1** Consider using the business case format to record exceptional expenditure decisions where funding is from existing budgets.

Personal Protective Equipment (PPE)

25. The use of PPE during the COVID-19 pandemic is vital in order to protect the wearer from contracting the infectious disease from contact with other people. In the early stages of COVID-19, the global demand for PPE increased significantly. At the same time, the global supply of PPE declined due to a fall in exports from China (the country that manufactures the most PPE) in February 2020. In addition, some countries imposed temporary restrictions on the export of PPE.
26. The Government therefore faced a significant challenge in the early stages of COVID-19 in sourcing PPE in an increasingly competitive and diminishing market, with a heightened risk of fraud from unscrupulous suppliers.
27. The main PPE items considered in my review are:
 - masks – surgical masks, visors, goggles and filtration masks
 - gloves
 - gowns
 - sanitiser; and
 - cleaning wipes.

Needs assessment and distribution

28. In a typical year prior to the COVID-19 pandemic, the Government was spending just under £200,000 on PPE. The need for clarity on PPE requirements was identified at a HCS meeting on 25 February 2020 and daily stock use was assessed from 2 March 2020. On 13 March 2020 the COVID-19 Bronze Group (the Bronze Group) noted that some PPE stock levels were high risk and all departments were asked to specify requirements. At the same time, the Bronze Group requested that the issue was escalated to the DHSC.
29. On 25 March 2020 a business case for PPE was considered by the COVID-19 Gold Command Group and a procurement strategy agreed with a focus on maintaining a consistent stock level based on a 21-day requirement. On 24 March 2020, the Bronze Group had also considered whether private health and care providers should continue to source their own PPE.
30. In April 2020, a Ministerial Decision confirmed that PPE would be made available free of charge to 'in-scope' organisations which could demonstrate a need for PPE to continue essential services.
31. A PPE co-ordination cell was established with 150 'in-scope' organisations and an Island-wide approach to PPE distribution started on 11 April 2020. Requests from 'in-scope' organisations were considered daily, with clinical input to provide an assessment confirming supplies were required to manage the COVID-19 risk in accordance with current guidelines.
32. There was no stock review of 'in-scope' providers by HCS and the process relied on the effectiveness of the risk stratification process alongside compliance by the organisations who were in-scope.
33. Exhibit 3 shows the projected PPE requirements identified by the Government at the beginning of April 2020.

Exhibit 3: Projected Island-wide PPE requirements

Category	Units of stock at 2/4/20	Ordered	Total	Forecast 3-month Island use	Outstanding requirement
Masks and eye protection	84,550	796,530	881,080	1,343,000	461,920
Gloves	3,111	2,412	5,523	198,600	193,077

Category	Units of stock at 2/4/20	Ordered	Total	Forecast 3-month Island use	Outstanding requirement
Gowns	32,323	2,045,220	2,077,543	3,280,800	1,203,257
Sanitiser	1,660	4,000	5,660	135,000	129,340
Cleaning wipes	2,389	840	3,229	196,920	193,691

Source: Presentation by Director General HCS 4 April 2020

34. The demand for PPE from April 2020 to July 2020 was less than forecast in the 'reasonable worst case scenario'. However to prepare for the risk of a second wave, on 23 July 2020 the Council of Ministers set out a requirement to acquire PPE stock, in addition to that already held, for the Island to be able to respond to a COVID-19 reasonable worst case scenario lasting 90 days. A business case was prepared subsequently which considered the requirement as well as two modified options which took account of existing stock levels.
35. On 21 August 2020, the Minister for Health and Social Services made a decision to acquire a 90-day stockholding after taking existing stock levels into account. The 90-day stockholding was introduced from 30 September 2020.
36. The case for Island-wide distribution of PPE at no cost was reviewed in detail in August 2020, in view of the cost to the taxpayer and the potential impact on the commercial viability of on-Island suppliers of PPE. The business case considered the affordability, sustainability and economic impact of a number of alternative options.
37. On 21 August 2020 the Minister for Health and Social Services approved that the public health arguments outweighed the commercial case and that Island-wide distribution should continue. Some changes were made by removing commercial and profit-making organisations from the scheme and concentrating supply on organisations directly related to maintaining the resilience of HCS. It was also agreed to seek options for sourcing PPE from local suppliers.
38. The business case referred to above was updated following the Minister's decision and indicates that, in the six month period to 6 September 2020, the total value of PPE distributed to non-Government organisations via the PPE co-ordination cell was £320,000. This is set out in Exhibit 4.

Exhibit 4: PPE distribution from PPE Cell April - September 2020

Provider	Total Value £	Total Quantity of Items	Number of Registered Locations
Government of Jersey Departments	747,635	4,401,812	209
Private			
Domiciliary Care	112,089	859,627	40
Care Home	104,864	1,115,238	48
Dentist Primary Care	39,272	9,290	35
General Practice Primary Care	36,635	174,703	22
Hospice	7,800	147,768	2
Optician Primary Care	6,230	64,594	13
Pharmacy	4,462	25,196	13
Charity	2,024	10,452	10
Airline	1,719	16,185	1
Other	1,350	12,891	13
Medical (private)	1,234	10,755	6
Nursery Pre School	938	8,110	23
Utilities Providers	816	1,372	6
Retail	664	1,496	6
Funeral Director	184	2,753	3
Total private	320,281	2,460,430	245
Total	1,067,916	6,862,242	454

Source: HCS Business Case - Island-wide Distribution of PPE September 2020

39. With regard to the domiciliary and care home providers which remained 'in-scope', the total of free PPE increased to over £1 million by the end of 2020.

Procurement

40. As the pandemic threat emerged in February and March 2020, and PPE demands increased, stocks diminished rapidly and supply pressures were becoming evident worldwide. An additional sum of £5 million was allocated from the General Reserve to provide adequate PPE for the pandemic. This was set out in a Ministerial Decision dated 7 April 2020.
41. Documentation was prepared to support the purchase of additional PPE using the allocation of £5 million. Masks, goggles and sanitiser were ordered in early April 2020. A business case for masks, face shields, gowns, gloves and wipes at a cost of £1.7 million followed with relevant PFM exemptions dated 12 April 2020. A further business case for face shields and visors was approved for £353,400. A second allocation of £1.92 million was provided to purchase masks, visors and gowns in April and May 2020.
42. In view of the unprecedented demand and supply chain problems, alternative options were explored by the Commercial Services team at the start of the pandemic. Potential suppliers were identified through local searches, networking, liaison with other jurisdictions including the UK, and following up a large number of suggestions from third parties. In practice, where there was an opportunity, local suppliers were used but this was predominantly for lower risk items. The Commercial Services team considered that, in the main, local suppliers could not supply the volumes required and did not have either the stock or the verified supply chain to assure the standards required.
43. Competing for PPE from new suppliers in a constrained market has a number of risks. These include the possibility of fraud, price escalation and quality risk as the normal process of requesting and testing samples for suitability is not always possible. The Government acknowledged and accepted the risks and took steps to mitigate these by:
 - undertaking basic commercial due diligence and resilience checks on all suppliers
 - resisting requests for advance payments
 - only agreeing payment once items were delivered and had passed quality checks; and
 - inclusion of a clause in purchase orders to allow cancellation without penalty if quality standards were not met.

44. Not all of these mitigations, however, were put in place for all suppliers. Some items were paid for entirely in advance if the suppliers' terms could not be renegotiated.
45. Large volumes of PPE supplies totalling £5 million were procured between March and May 2020 as summarised in Exhibit 5. In addition to this, the Government sourced gloves and a small volume of clinical wipes from the NHS supply chain via the weekly allocation made available from the DHSC. The balance of gloves and wipes required was purchased from more than 10 other suppliers including local companies.

Exhibit 5: Major PPE procurement March to May 2020

Supplier /item	Supply (Business Case)	Value £	Issues	Procurement Exemption/ Breach
A1	Masks and sanitiser	1,924,800	Concern over quality of masks within order. The company agreed to replace all and at the time of my review, they were en route from China.	Exemption No tender process.
A2	Gowns (BC 26)	900,000		Exemption No tender process.
B	Gowns	489,365	Quality of product variable. Some sub-standard. Investigation in progress.	Exemption No tender process.
C	Masks (BC26)	593,700	Authenticity concerns in respect of regulated product. Investigation in progress.	Procurement procedures not followed. No exemption or breach logged.
D	Shields and visors (BC26)	124,447	Conformance concerns resolved with further evidence provided by the supplier.	Breach - detail not available.

Supplier /item	Supply (Business Case)	Value £	Issues	Procurement Exemption/ Breach
E	Various e.g. Gloves and wipes (BC26)	576,970		Not required - small volumes or existing suppliers.
F	Face shields/visors (BC27)	353,400		Exemption.
		4,962,682		

Source: Government of Jersey Procurement Exemptions and Breaches logs and records. PPE Business Cases (where available)

46. Within the above total, around £1.8 million of PPE supplies that had been purchased from four suppliers were referred for further investigation following quality concerns on inspection. Whilst volumes were validated on delivery, quality tests were not performed promptly prior to full payment being made. As a result, the Government is now engaging with the suppliers to seek remedy. Officers have resolved two of these satisfactorily, by agreeing replacement supplies in one case (supplier A), and by receipt of the appropriate documentation of authenticity in another (supplier D). Investigations on two suppliers (suppliers B and C) continue with support from the Law Officers' Department and specialist UK agencies.
47. The PFM requires disclosure of an exemption or breach of procurement guidance where the Government has not adhered to its own procurement rules. In my report on *Anti-Corruption Arrangements* (January 2021), I acknowledged that there may be occasions when deviation from procurement guidance is appropriate, but I emphasised the value of a robust process to record and monitor exemptions and breaches. The total value of exemptions and breaches logged between April and June 2020 when PPE was procured is shown in Exhibit 6.

Exhibit 6: Procurement exemption and breaches April to June 2020

	Total on log (April - June) £	PPE only £
Exemptions	17,994,107	4,137,566
Breaches	858,019	136,062

Source: Government of Jersey Commercial Services team exemptions and breaches logs

48. I have reviewed the Covid-19 Breach and Exemption logs and documentation in respect of the relevant exemptions and breaches from Exhibit 5. My review showed compliance, with the following exceptions:
- item A2 (£421,750) - the exemption form was completed in the higher sum of £901,250. An entry was not recorded on the exemption log
 - item C (£593,700) - not recorded as an exemption or breach; and
 - item D (£124,447) - whilst two breaches have been logged in the sum of £68,750, the breach forms were not available for review. I understand that a retrospective breach form is to be completed in respect of this procurement for the full final sum of £124,447.
49. Since the peak procurement period in March and April 2020, the Government has been successful in receiving supplies through its relationship with the UK Government. The DHSC introduced its 'PUSH Pallet' Approach in April 2020 which allowed Jersey to receive COVID-19 consumables free of charge as a Crown Dependency. The Government prioritised ordering from the UK under these terms rather than purchasing from the open market. Until the 90-day stockholding was introduced from 30 September 2020, this ensured that supply levels were maintained at the 21-day target level. The UK source remained resilient due to levels of PPE procured by the UK, alongside growth in UK based manufacturing options which reduced reliance on global markets and supply chains.
50. At the time of this report, stock is being monitored closely alongside the 90-day requirement. A report dated 11 January 2021 indicated that stockholdings are well in excess of 90 days for all items based on current usage. However, if the 'reasonable worst case scenario' forecast is used, five items are showing as 'at risk'. Exhibit 7 shows the stock levels in January 2021.

Exhibit 7: PPE January 2021 compared to actual use and 'reasonable worst case scenario'

Item	Stock 11/01/21	Average daily use	Stock (days)	Worst case daily use	Stock (days)
Surgical masks	1,067,168	4,064	263	12,000	89
Filtering facepiece masks	208,680	61	3,397	5,600	37
Gowns - sterile and non-sterile	353,825	402	880	3,430	103
Shields, visors, goggles	349,644	66	5,321	2,338	150
Gloves	3,833,660	23,731	162	51,600	74
Aprons	2,215,000	6,171	359	22,400	99
Wipes	3,116,350	14,889	209	41,800	75
Sanitiser - 500ml	29,881	36	820	209	143
Sanitiser - 50-100ml	131,573	31	4,244	1,492	88

Source: Multi-agency Information Cell data report 11 January 2021

51. The procurement strategy for 90-day PPE stockholding following the Ministerial Decision on 21 August 2020 focussed on three supply options as follows:
 - items provided free of charge from the DHSC/NHS allocation. This was as agreed previously based on maintaining 21 days' stock levels
 - negotiation with the DHSC resulting in agreement that the DHSC would act as supplier for additional items above the allocation; and
 - independent suppliers.
52. In practice, the request for 90-day stock did not meet the criteria to qualify for the 'free of charge' DHSC allocation. Local suppliers were approached to provide quotes on price and availability at the same time as the DHSC was approached to act as supplier.
53. The responses from local suppliers to the 'request for quote' exercise did not demonstrate sufficient immediate availability to meet the requirement. The Commercial Services team considered that the fragility of the local supply chain was too much of a risk unless supply was readily available. The DHSC confirmed

that it could meet the requirement, with the exception of clinical wipes which the Government instead procured from a local supplier.

54. A record of items ordered via the DHSC was maintained as payment was not required immediately. The unit price of a number of PPE items increased significantly over time and officers wanted to be in a position to ensure that a proper audit trail was available to support future payment demands. In early January 2021, the DHSC advised that it would not be seeking payment for any PPE provided to the Government in 2020, including the allocation to Jersey and additional items procured for Jersey by the DHSC. However, recharges will commence from 2021. It is estimated that to date, the Government has benefitted from free supplies from the UK in excess of £5 million. The Government is now liaising with the DHSC to understand the rationale for the change in policy and to obtain a price list to provide assurance in relation to value for money.

Recommendations

- R2 Ensure that exemption and breach documentation and logs are accurate and complete in respect of all departures from the Public Finances Manual.
- R3 Ensure that all future supplies are reviewed for quality as well as quantity on receipt prior to approval of payment.
- R4 Ensure that a reassessment of alternative options for the supply of PPE is undertaken when the DHSC provides details of prices to be charged in 2021.

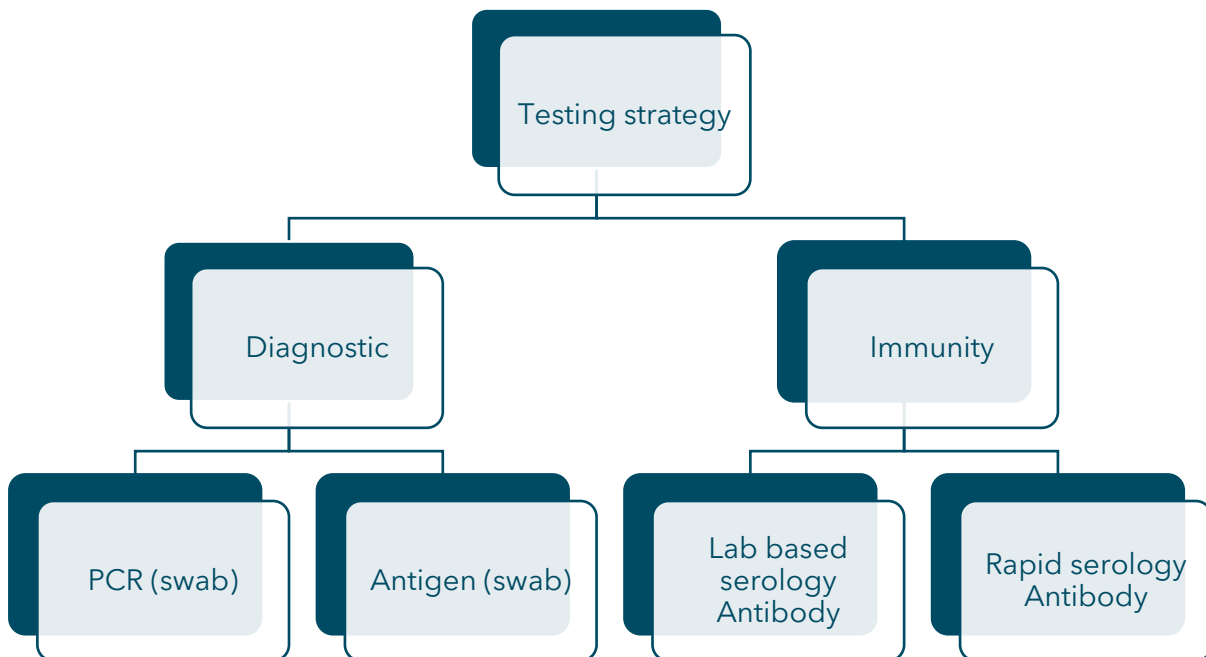
Testing kits

55. The States agreed a 'delay, contain and shield' strategy to respond to the pandemic which included a Test and Trace Programme. An 'Island Wide Testing Programme' was a key workstream within this programme agreed at the Competent Authorities Meeting on 17 April 2020. Five elements of the programme were outlined in the business case dated 3 May 2020:
- increasing Jersey's diagnostic Polymerase Chain Reaction (PCR) testing capacity to 500 tests per day
 - conducting a longitudinal community survey to monitor the presence of COVID-19 antibodies
 - establishing laboratory-based serology testing capacity for diagnostic and surveillance purposes

- introducing immunity testing, if and when this became viable; and
- securing a resilient multi-jurisdiction supply chain to support the delivery of these activities.

56. Implementation of this programme required evaluation of a range of options for different antigen and antibody tests to be used in parallel for diagnostic and surveillance purposes. The strategy had to be flexible to accommodate availability of supplies, new solutions and the need for regulation of emerging products. The strategy considered options for procurement of test kits and laboratory capacity for antigen and antibody tests as shown in Exhibit 8.

Exhibit 8: Testing strategy for diagnosis and immunity



Source: Government of Jersey overview of testing options

57. My review has focussed on the initial business cases and procurement in respect of testing kits. Initiatives such as Test to Travel will be considered in my planned work on test, trace and vaccine roll out.

Needs assessment

58. An urgent business case for the procurement of rapid serology testing kits for mass antibody testing was approved by the Minister for Treasury and Resources on 2 April 2020. A further detailed business case produced on 3 May 2020 set out the objectives and options for the wider testing programme. At the time of this earlier business case, there was no COVID-19 testing on-Island using PCR or

serology, which exposed the Island to the risk of reliance on the UK for both supplies and testing capacity. Therefore, part of the strategy was to establish on-Island capacity of up to 500 tests per day.

PCR testing

59. The business case for the testing programme dated 2 April 2020 noted that by 31 March, 962 PCR tests for viral infection in patients had been processed. The swabs were provided via the UK NHS supply chain and initially processed within 48 hours by the PHE laboratory. PCR diagnostic testing for COVID-19 was established on-Island from April 2020 at a cost of £100,000 for additional laboratory resources and £97,000 for a back-up analyser to support the existing platform. This also provided capacity to test for COVID-19 quickly as well as other infections in critically ill patients. 10,000 swabs and test kits were ordered at the end of March 2020 with the first batch of 1,500 delivered by the first weekend in April 2020.
60. The PCR testing capacity was planned to increase to 500 tests per day by mid-May 2020. This would allow PCR tests to be part of the screening programme as well as diagnosis. This was achieved through a combination of available capacity from three sources shown in Exhibit 9.

Exhibit 9: PCR daily testing capacity target May 2020

Location	Volume	Comments
On-Island	100	Maximum capacity 192 but agreed to keep some capacity free for other analysis
PHE Laboratory	175	Existing processing capacity increased to 175 by agreement on 27 April 2020, free of charge
Commercial	300	Commercial laboratory capacity to be purchased up to 300 tests per day on 'pay as you go' basis. A procurement exemption for this was dated 11 May 2020
Total	575	

Source: Government of Jersey Island-wide testing business case

Rapid serology testing

61. As noted above, the early business case on 2 April 2020 addressed the need for rapid serology test kits to enable Island-wide testing for antibodies. The initial business case prioritised cohorts of the population.

62. A total of 150,000 tests was initially proposed which was subsequently increased by 50,000 when an opportunity arose to procure further tests. The business case acknowledged that it was impossible to predict test volumes required with any certainty. Total volume was based on an assumption that 60,000 people would be tested at least once a month. This would require sufficient locations and workforce to process 2,000 tests per day or 3,000 per day excluding weekends. The business case does not set out how this would be managed and what the cost would be. The rapid serology tests were estimated at a cost of £2.4 million and the business case set out a range of benefits including:
- reducing the number of patients becoming infected or critically ill and the number of deaths
 - reducing the overall number of people becoming infected and the number of critically ill patients, reducing hospital costs for clinical care of COVID-19 patients
 - enabling workers to return to work sooner which would allow businesses to resume trading
 - reducing the length of time that financial support packages were in place for individuals and companies
 - recovery from the decline in tax revenue quicker; and
 - recovering Goods and Services Tax (GST) revenue quicker.
63. The value of the above benefits was not quantified.

Laboratory-based serology testing

64. The platforms for laboratory-based serology testing were already in place and the needs assessment therefore focussed on volume and type of test. The business case dated 3 May 2020 set out the objective to use one platform for tests for antibodies for diagnostic purposes. The second platform would be used for Unlinked Anonymous Testing (UAT) of antibodies using routine biochemistry samples as part of the surveillance programme, as well as providing back up for the first platform.

Procurement

65. The overall procurement cost of the three types of testing as part of the Island-wide programme was estimated as £5.72 million in the supporting business cases referred to above. The analysis is shown in Exhibit 10.

Exhibit 10: Estimated costs of initial Island-wide testing programme

Business case	Estimated £	Actual £
PCR testing	2,935,793	4,716,306
Rapid serology	2,618,000	1,345,090
Laboratory-based serology	73,500	2,172
Additional back-up technology (excludes staffing estimated at £100,000)	97,000	97,536
	5,724,293	6,161,104

Source: Island-wide testing business cases prepared by Strategic Policy, Planning and Performance Department April and May 2020

PCR testing

66. The total estimated cost of PCR testing calculated on 1 May 2020 as part of the wider programme was £2.9 million, based on 500 tests per day for a 7 month period or 108,500 tests ('the expected case'). The breakdown of this cost is shown in Exhibit 11.

Exhibit 11: Estimated costs of initial PCR testing programme

Cost analysis	Capacity %	Expected cost £
On-Island*	20	694,400
Commercial	45	2,001,825
PHE Laboratory	35	0
Swabs		86,800
Estimated carriage costs		151,900

Cost analysis	Capacity %	Expected cost £
Wastage		868
Total		2,935,793

Source: Government of Jersey Business case (03/05/20), procurement exemption (11/05/20) and financial analysis (01/05/20)

**Excludes cost of back-up equipment of £97,000*

67. My review of the procurement process indicates that proper processes were followed to enable the Government to demonstrate value for money as far as possible in the circumstances.
68. Test kits for the existing on-Island analyser were purchased from the existing supplier at a cost of £474,000 compared to the estimate of £694,400. This was expected to meet up to 20% of the modelled expected demand assuming capacity was increased through extended use of the hardware. Initially these test kits were only available from the United States but then became available via the company's European supply chain.
69. A commercial laboratory solution was required alongside development of on-Island capacity as the available capacity from PHE was capped. The commercial capacity was on a 'pay as you go' basis and intended to make up for any shortfall from other sources.
70. Procurement of commercial laboratory capacity did not follow the procurement guidance in the PFM due to the urgency. However, a detailed business case was prepared alongside the appropriate procurement exemption in the sum of £2.1 million. A further exemption in the sum of £5.7 million was prepared in August 2020 to reflect the increased volumes.
71. The records show that the commercial risk was mitigated as follows:
 - the supplier was already a supplier to the Government
 - some market testing was undertaken with a competitor which demonstrated similar unit costs
 - the unit cost was consistent with charges to the UK NHS and close to prices obtained from one other competitor identified as having spare capacity
 - the laboratory was accredited; and

- the draft service level agreement was reviewed by the Commercial Services team to obtain assurance on the ability to deliver the requirement.
72. The capacity available through the PHE laboratory was provided at no charge. If this capacity of up to 35% had not been available, the estimated costs would have increased by between £1.2 million and £1.5 million depending on whether tests were processed on-Island or off-Island.
73. The cost of swabs was not significant in the context of the Government's expenditure on the COVID-19 response. The estimate in Exhibit 11 above assumed that the Government would have to procure these independently. At the time of the business case in early May 2020, an agreement was in place with a commercial supplier to provide a three-month supply at a cost of £24,000. In practice, after this initial procurement, swabs for PCR testing were procured from the UK DHSC National Supply Disruption Response (NSDR) at no cost.

Rapid serology testing

74. The Government identified a need for 150,000 rapid test kits in the business case dated 2 April 2020 and then added a further 50,000 as an addendum to the business case on 5 April 2020. Certified testing kits were not available at the time, so the available options were to:
- acquire directly a non-certified serology solution and ensure clinical quality ahead of use
 - acquire a serology solution via the UK; or
 - do nothing now.
75. The final option was discounted as it was considered that the benefits of testing outweighed the commercial risk and, at the time, access to PCR testing was limited. The option to secure supplies via the UK was discussed with UK Government Departments that confirmed that there would be options for the Government of Jersey to procure via the NHS supply chain. However, the UK timetable for a clinically validated mass testing solution was not clear. A decision was therefore taken to procure uncertified tests directly.
76. The largest part of the supply was procured from a supplier via a distributor following evaluation of four options from different suppliers. Commercial due diligence was carried out to manage the commercial risk. A part payment in advance was required which was a deviation from guidance in the PFM. An exemption form was completed in respect of this supply although I note that this was not recorded in the exemption log.

77. At the time of the procurement, there were no available COVID-19 rapid tests approved by regulators and the quality specification was based on Chinese laboratory tests. Samples were also being evaluated by UK universities. The above supplier's test was not submitted to the US Foods and Drug Administration (FDA) and was removed from the FDA 'pending' list on 23 December 2020.
78. The test kit from the second supplier was brought to the Government's attention after the initial business case, following an approach from a local resident and a journalist. The distributor was contacted and once the test had undergone the same scrutiny as the other options, it was added as an addendum to the business case. These test kits were considered to have comparable characteristics to the earlier order but with the advantage of a better supply chain as they were in a bonded store in the USA. There was however a risk of US Government confiscation at the time for domestic use. The agreement provided for a full refund should this occur.
79. As this was a new supplier, the Government carried out basic due diligence tests in addition to the mitigation of the commercial risk in the same way as the first supplier. An exemption to the procurement process was completed for this supply as there was no tender process and part payment in advance was required. 50,000 of these test kits were ordered at a price 30% above the unit cost in respect of the supply of 150,000 of the kits from the first supplier (£14.34 v £11.00 (£12.56 including freight)).
80. The exemption to procurement guidance states that the test kits were 'approved for release by the FDA on 6 April 2020' and the addendum to the business case states that further trials to secure FDA approval will follow. FDA records show that the second supplier's test kit received FDA Emergency Use Authorisation (EUA) on 29 May 2020. This allowed the test kit to be used in authorised laboratories only. The EUA does not mean that the test kit is cleared or approved by the FDA. Press reports in the USA in mid-April 2020 suggest that the validation evidence in China was from third-party researchers and the second supplier's test had not been approved by the Chinese national regulator. By 1 April 2020 China had banned further export of all test kits that had not been approved but a large number had already been distributed.
81. In both cases, the Government's documentation is clear that procurement was undertaken on the basis that the test kits had a 'CE' Certificate of Conformity but that further clinical validation would be undertaken in the Island laboratory before deployment of the tests. This was in addition to the evaluation being undertaken by UK universities.
82. The Government received 100,000 test kits from the two suppliers in batches starting on 15 April 2020. The total estimated cost for these is recorded in the

business case for Island-wide testing as £1.3 million. The clinical validation tests demonstrated that these tests did not fully satisfy the Medicines and Healthcare products Regulatory Agency (MHRA) specification criteria.

83. More accurate PCR testing capacity had increased during April 2020 which led to a refocus of the testing strategy on to diagnosis. A re-evaluation of the demand for rapid serology tests as part of the Island-wide testing business case dated 3 May 2020 concluded that 100,000 rapid serology tests already delivered would be sufficient for 12-18 months. Orders for 100,000 rapid serology testing kits were cancelled and £1.1 million of the estimated £2.4 million was returned to the General Reserve.
84. Whilst the test kits will not be used in the way initially envisaged, the purchased test kits have been used to date for:
 - prevalence testing from 2 May to end June 2020, with results adjusted for the likely accuracy evidenced from the clinical appraisals; and
 - management of active cases of COVID-19 following identification using PCR tests.
85. The results of the community and essential worker testing have been publicly reported and are transparent in reporting a degree of uncertainty in performance characteristics. As at 10 March 2021, 16,462 test kits had been used from the first supply of 50,000 and 5,000 from the second supply of 50,000. The remaining 78,538 rapid test kits have a shelf life of up to 2 years.

Laboratory-based serology testing

86. The laboratory-based serology testing used two existing platforms and suppliers. The business case dated 3 May 2020 indicates that procurement exemptions would be required for both suppliers. However, no exemptions are logged. Both existing suppliers released tests at an early stage and discussions focussed on selection of the most appropriate test for the Island's needs. Option analysis was undertaken to identify worst, expected and best-case scenarios in terms of volumes required. Test kits were then sourced on the basis of the expected capacity. The business case was prepared in anticipation of purchasing diagnostic tests at a cost of £30,000 from one supplier and tests for surveillance totalling £40,000 from the other. As the tests on these platforms require a blood sample from a vein rather than pin-prick, the volume of testing is constrained and use has been significantly less than was anticipated when the business cases were prepared. At the year end, total expenditure on tests was recorded as £2,172.

Recommendations

- R5 Carry out a review of the procurement of rapid serology test kits and subsequent evidence to assess lessons to be learnt from the process.
- R6 Review future demand for rapid serology test kits and agree a disposal strategy to recoup investment where possible if excess supply is identified.

The Nightingale Hospital

- 87. A Nightingale Hospital was constructed rapidly in April and May 2020 to provide the Government with additional temporary bed capacity. Funding of up to £14.4 million was allocated from the General Reserve by Ministerial Decision on 9 April 2020 to cover the cost. The speed of planning and commissioning the project was such that the usual competitive tendering exercise was not practical. Exemption from the procurement guidance in the PFM was documented and steps were put in place to manage the commercial risk.

Needs assessment

- 88. The need for an additional hospital surge facility to manage the potential volume of COVID-19 patients requiring hospital care was agreed by the Competent Authorities Group at the end of March 2020. This was based on modelling undertaken by the Jersey Statistics Unit dated 16 March 2020, using public health data and the 'reasonable worst case scenario' from the PHE/SAGE model.
- 89. Options considered included a military style field hospital, using an existing building or constructing a new temporary facility. On 6 April 2020, the Competent Authorities Group requested a report on options by 8 April 2020. The case presented indicated that no existing buildings were suitable and recommended a Nightingale Hospital based on a UK model. A range of sites was considered before agreement that the site at Millbrook would be the most appropriate. This was on the basis of site characteristics and proximity to the hospital which would enable it to be treated as a 'wing' of the Jersey General Hospital (JGH). Use of the site and reinstatement of the site was agreed with the owners. Planning permission was not required as this was a 'permitted development' for a short period.
- 90. A detailed business case was prepared for a 180-bed temporary hospital following an assessment of current bed capacity in the JGH and community. This would provide a total bed capacity of 532 with the potential for a further 68 in the system as shown in Exhibit 12.

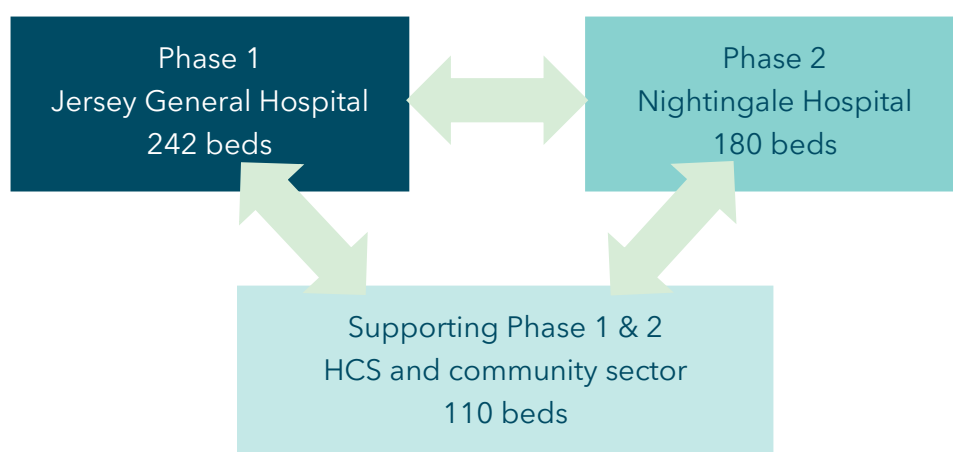
Exhibit 12: Bed capacity April 2020

Location	Beds
JGH - surgical and Intensive Therapy Unit	94
JGH - reserve beds	148
Total JGH - Phase 1	242
HCS community	45
Community sector	65
Total existing capacity	352
Nightingale Hospital (when fully commissioned)	180
Total capacity	532
Possible additional beds	68
Maximum	600

Source: Government of Jersey System wide capacity plan

91. The surge capacity figure of 180 beds emerged from a range of potential needs modelled by the Government in March 2020. These were based on a principal scenario assumption adjusted to produce different scenarios which took account of the impact of measures in place (such as travel restrictions and physical distancing).
92. The Government considered the total bed capacity to be appropriate on the basis of a phased model shown in Exhibit 13. Phase 1 is the core hospital capacity at the JGH. This is supported by the 180-bed surge capacity at the Nightingale Hospital with 110 beds initially available elsewhere as 'step-down' (intermediate care) capacity for both main facilities.

Exhibit 13: Phasing of the Jersey Bed Plan



Source: Government of Jersey System wide capacity plan

93. The need for the Nightingale Hospital was assumed to be for up to four months when it was approved. It was designed as a modular facility with six 30 bed wards allowing expansion in use based on demand. The business case dated 9 April 2020 identified a total cost of £14.4 million plus estimated running costs of £4.3 million for the four month period, including £3.3 million for staffing. At the time of the business case, the operational plan was in the process of being finalised and the risk of staff non-availability was not quantified.
94. To date, the Nightingale Hospital has not been required. The temporary facility was extended until at least March 2021 and has since been extended to June 2021. The cost of the extension to March is included in the Government Plan 2021 - 2024 at £8.4 million.
95. The extension to the Nightingale Hospital lease into the winter brought the risk of damage due to adverse weather as the structure might be susceptible to damage from high winds or snow above the assessed snow load. The supplier requires the structure to be returned in good condition and the States are liable for the cost of damage to any of the structure panels during the commissioning period. Provision for this risk is included in the costs above.

Procurement

96. The initial project cost of the Nightingale Hospital presented to the Competent Authorities Group was estimated as £13.2 million plus £190,000 for IT equipment. The Treasurer's approval on 15 April 2020 shows a drawdown of funds of £12.46 million (excluding contingency of £1.3 million) from the allocation of £14.4 million approved by the Minister for Treasury and Resources in a decision dated 9 April 2020, as shown in Exhibit 14. At this time, as well as the contingency of £1.3 million, a sum of £460,000 was unallocated in respect of the fit-out and equipment for the site.

Exhibit 14: Nightingale Hospital cost estimates – April 2020 and actual to December 2020

Project element	Business Case	Agreed allocation	Treasurer Approval	Actual
	09-Apr £m	14-Apr £m	15-Apr £m	To 31 Dec £m
Infrastructure, Housing and Environment (IHE) Expenditure				
Design and build	6.30	6.00	6.30	6.58
Utilities upgrade	1.00	1.00	1.00	
Temporary structure	1.00	1.00	1.00	1.09
Oxygen		0.80	0.80	0.82
Equipment Hire				0.15
Ancillary costs				0.09
Running costs (power)				0.02
	8.30	8.80	9.10	8.75
HCS expenditure				
Equipment fit out	4.80	3.20	3.36	0.80
	4.80	3.20	3.36	0.80
Total	13.10	12.00	12.46	9.55
Contingency	1.30	1.30	1.30	
Total including contingency	14.40	13.30	13.76	9.55
HCS Funding - Beds		0.64	0.64*	0.56
Total Budget/Cost	14.40	13.94	14.40	10.11

*Treasurer decision adjusted to exclude £640,000 allocation from HCS budgets for beds

Source: Business case, correspondence and Treasurer's Decision 15/04/20. Actuals from published response to a Freedom of Information request

97. At 31 December 2020, the total cost of commissioning the Nightingale Hospital was £10.11 million, being the additional funding of £9.55 million allocated to IHE from the General Reserve plus HCS expenditure on beds of £557,820 from existing budgets. HCS spent a further £644,888 on running costs such as consumables and staff training. The total expenditure on procurement and operation in 2020 was therefore £10.8 million.

Structure

98. The Government approached J3 to design and construct the Nightingale Hospital. J3 is an Island based joint venture developer known to the Government as it was previously selected as pre-construction partner for the Future Hospital Project. J3 was available with on-Island capacity at the time of the build requirement and was able to draw on the experience of McAlpine as one of the Joint-Venture partners who had built the Nightingale Hospitals in four UK sites, including Manchester and Glasgow.
99. In the absence of a competitive tendering exercise, exemptions to the procurement process were prepared for all of the elements of the project as permitted by the PFM. Initially, separate exemptions were prepared for the design and build contract and the building supply on 9 April 2020. A subsequent overarching exemption including these elements as well as equipment was prepared on 11 April 2020. Records show that expenditure on design and build and the structure was only committed after the exemption was prepared and signed by the Accountable Officer. However, the exemption documents are not formally authorised by the Director of Commercial Services as required by the PFM. The overarching exemption dated 11 April 2020 was not authorised by the Accountable Officer until 16 April 2020 which was after the Letter of Intent was agreed for the oxygen supply.
100. I have seen evidence of correspondence between officers in this period to confirm that, despite these omissions in the formal records, all appropriate parties were aware of the procurement and contributed to the decision making process. Exhibit 15 summarises the detail.

Exhibit 15: Nightingale Hospital procurement exemptions April 2020

Exemptions	Value £m	Date expenditure committed	Exemption form date	Accountable Officer approval date	Commercial Services approval date
Design and delivery	7.40	09/04/2020 Letter of Intent for £2m	09/04/2020	09/04/2020	N/A
Structure supplier	1.19	09/04/2020 Order placed with payment in advance of £335,000	09/04/2020	09/04/2020	N/A
Overarching:		09/04/2020	11/04/2020	16/04/2020	N/A
Design and delivery	7.40				
Structure	1.00				
Equipment and oxygen	4.80	12/04/2020 Letter of Intent	N/A	12/04/2020	
IT equipment	0.19				
	13.39				

Source: Procurement Exemption Forms April 2020

101. The initial cost estimates were based on best available data at the time including typical equipment costs prepared by J3 on the basis of experience elsewhere. Planning and building control fees estimated at £158,000 were waived by Ministerial Decision on 14 April 2020.
102. Following a desktop exercise, a Dutch Company, Neptunus, was contacted on 5 April 2020 to discuss providing a temporary modular structure which would be erected by specialists and hired by the Government for the period. A review of the Neptunus structure was carried out by the Nightingale Hospital project team and J3 on 6 April 2020. This satisfied the technical aspects and a layout was developed for approval of HCS representatives in the project team. At the time, Neptunus was delivering a similar building in Cardiff.
103. The commercial risk associated with the procurement of J3 was assessed as low as it was an existing supplier. In addition, officers were able to renegotiate existing

rates and agreed third party scrutiny of the contract and any payments. The risk assessment associated with Neptunus was managed by undertaking basic due diligence, reference to the company's track record in delivering similar solutions and by agreeing a staged payment arrangement.

104. At the time of my fieldwork, a detailed decommissioning strategy had not been prepared. The Neptunus contract includes dismantling of the structure but a plan is required for the internal structures, fittings and equipment and reinstatement of the site.

Oxygen

105. The initial project estimate for the Nightingale Hospital included provision for additional non-invasive oxygen capacity within the estimate of medical equipment. The cost was estimated at £465,000.
106. Procurement of oxygen in early April 2020 was extremely challenging for the Government due to scarce supplies of therapeutic oxygen worldwide. A decision was taken to purchase and install an oxygen making plant to ensure that the Nightingale Hospital had sufficient provision. This was procured on a single source basis from Ireland with an acceptable delivery time but at a cost significantly in excess of the estimate. However, other costs were below estimate which allowed overall costs to be contained within the original estimate.
107. The Government carried out basic due diligence on the supplier and agreed staged payments to manage the risk. A separate business case was suggested for the oxygen plant at the time as this deviated from the original intention. There is no evidence that this was completed nor is there an exemption form completed in the proper format. However, some documentation is available which sets out the rationale and commercial risk mitigation and I have seen detailed evidence supporting the rapid decision making process.

Medical and IT equipment

108. At the time of preparing the overarching exemption for the Nightingale Hospital, including medical equipment and oxygen, the detailed specification and costs were still to be determined. The overarching exemption is therefore limited on detail on the nature of the exemption and the mitigation of any specific commercial risks. No cost implication related to the exemption is shown in the COVID-19 exemption log.
109. The Nightingale Hospital was designed in a modular structure of six 30 bed wards which would allow for phased commissioning based on demand. As the decision was based on surge capacity of 180 beds identified as needed in the 'reasonable worst case scenario', medical equipment was procured for the whole hospital from

the start and delivered in phases. Final equipment needs were determined by HCS in collaboration with J3 and an independent health planning consultancy. A detailed room by room schedule was developed from recognised hospital equipment databases. HCS applied two principles, minimisation and limited fixing to walls, in finalising the schedule by 14 April 2020. Earlier iterations of the equipment schedule were shared with the Commercial Services team from 7 April 2020 to enable the procurement process to commence.

110. The budget included in the Treasurer's approval was £4.16 million which included all medical equipment, fixtures and fittings, IT equipment and oxygen. The total spent on medical equipment (excluding oxygen and IT equipment) was £1.2 million. Orders were placed between 10 April 2020 and 19 May 2020 with items delivered from 24 April 2020 to 1 July 2020.
111. IT and telephony equipment totalling £190,000 was specified in detail and procured from the existing suppliers.
112. The opportunity to repurpose existing medical and IT equipment for the Nightingale Hospital was considered but there were only limited opportunities to do this given the scale of the Hospital. As a result, the equipment and fixtures are largely new items.
113. The cost per bed purchased was £898, the typical supply cost, (£161,640 in total) and was covered by the overarching exemption. The procurement case included the potential to use the beds in the JGH post pandemic. However, it is not clear if this will be possible.
114. As the decision was for provision of a 180-bed hospital at a specific point in time, no consideration appears to have been given to the potential to equip the Nightingale Hospital in phases as the demand for the facility became apparent. Instead, whilst deliveries were phased with a focus on at least 50 beds being available from the start, the Nightingale Hospital was kitted out completely from the outset in a single procurement approach. A phased approach could have reduced overall costs if the facility had in fact been required only in part or not at all.
115. At the time of my fieldwork there was no decommissioning plan in place for the Nightingale Hospital medical and IT equipment. Some of the supply (such as beds) may not be appropriate for use in the JGH and therefore options for future use for all items need to be determined.

Recommendations

- R7** Complete a detailed procurement strategy to agree costs and plan for decommissioning the Nightingale Hospital site.
- R8** Prepare a detailed decommissioning plan for the Nightingale Hospital equipment that minimises financial loss to the States.

Appendix One

Audit Approach

The review included the following key elements:

- review of relevant documentation provided by the Government of Jersey
- liaison with the UK National Audit Office; and
- interviews with key officers within the Government of Jersey.

The documentation reviewed included:

- Presentation material - COVID-19 - Critical Care and PPE (4 April 2020)
- System wide capacity plan for COVID-19
- Presentation documentation re Jersey Field Hospital (8 April 2020)
- Business case - Surge Facility Field Hospital
- Business case - Nightingale Hospital (January to March 2021)
- Internal Audit Report - Nightingale Hospital (October 2020)
- Nightingale Hospital Room Data Schedule 14 April 2020
- Nightingale Hospital Master Equipment Lists
- Business cases - Testing Programme (On-island serology including addendum, Test and Trace Programme Framework, Island-wide Testing)
- Island-wide testing Programme - Financial Summary
- Business case - COVID-19 PPE
- Business case - Island-wide distribution of PPE and Ministerial Briefing/advice
- Personal Protective Equipment - Briefing Document
- PPE Future Framework 24 July 2020
- PPE portal guidelines, requester master list and process documentation

- PPE monitoring records - Multi Agency Information Cell (MAIC)
- Covid-19 Medical Equipment Schedule
- Health and Social Security Scrutiny Panel - Review of Government Plan 2021 - 2024
- Relevant documentation supporting exemptions from procurement processes
- Responses to relevant Freedom of Information requests.

The following officers were interviewed remotely or provided written input:

- Group Director, Commercial Services
- Acting Director General, Infrastructure, Housing and Environment
- Group Managing Director, HCS
- Director General, Justice and Home Affairs
- Director, Strategy and Innovation, Strategic Policy, Planning and Performance
- Associate Managing Director (Operations), HCS
- Associate Managing Director (Care Groups), HCS
- Chief Nurse
- Head of Non-Clinical Support Services, HCS
- Global Category Lead (HCS), Commercial Services
- Head of Category Management (IHE), Commercial Services
- Head of Category (Professional Services), Commercial Services
- Head of Procurement (HCS), Commercial Services
- Head of HCS Non-Clinical Support Services/PPE Cell Senior Responsible Officer
- Head of Finance Business Partnering (IHE)
- Director, Risk and Audit
- Chief Internal Auditor
- Internal Audit Contractor

I would like to thank all officers who have contributed to this report.

The fieldwork was carried out by an affiliate working for the Comptroller and Auditor General.

Appendix Two

Summary of Recommendations

- R1** Consider using the business case format to record exceptional expenditure decisions where funding is from existing budgets.
- R2** Ensure that exemption and breach documentation and logs are accurate and complete in respect of all departures from the Public Finances Manual.
- R3** Ensure that all future supplies are reviewed for quality as well as quantity on receipt prior to approval of payment.
- R4** Ensure that a reassessment of alternative options for the supply of PPE is undertaken when the DHSC provides details of prices to be charged in 2021.
- R5** Carry out a review of the procurement of rapid serology test kits and subsequent evidence to assess lessons to be learnt from the process.
- R6** Review future demand for rapid serology test kits and agree a disposal strategy to recoup investment where possible if excess supply is identified.
- R7** Complete a detailed procurement strategy to agree costs and plan for decommissioning the Nightingale Hospital site.
- R8** Prepare a detailed decommissioning plan for the Nightingale Hospital equipment that minimises financial loss to the States.



JERSEY AUDIT OFFICE

LYNN PAMMENT

Comptroller and Auditor General

Jersey Audit Office, de Carteret House, 7 Castle Street, St Helier, Jersey JE2 3BT
T: +44 1534 716800 E: enquiries@jerseyauditoffice.je W: www.jerseyauditoffice.je